DOCUMENT RESUME

ED 463 509 CG 031 678

TITLE	About Mental Health in Schools. An Introductory Packet.
INSTITUTION	California Univ., Los Angeles. Center for Mental Health in Schools.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Washington, DC. Maternal and Child Health Bureau.; Substance Abuse and Mental Health Services Administration (DHHS/PHS), Rockville, MD. Center for Mental Health Services.
PUB DATE	2002-04-00
NOTE	51p.
CONTRACT	U93-MC-00175
AVAILABLE FROM	School Mental Health Project, Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563. Tel: 310-825-3634; Fax: 310-206-8716; e-mail: smhp@ucla.edu. For full text: http://smhp.psych.ucla.edu.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	*Comprehensive School Health Education; Delivery Systems; *Educational Environment; Elementary Secondary Education; Intervention; *Mental Health Programs; Outcomes of Education; *Program Development; School Community Relationship; *School Counseling; School Role

ABSTRACT

This introductory packet provides an overview of what the term "Mental Health in Schools" means. The packet discusses how school-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. It asserts that advancing mental health in schools is about much more than expanding services and creating full service schools. It is about establishing comprehensive, multifaceted approaches that help ensure schools are caring and supportive places that maximize learning and well being and strengthen students, families, schools, and neighborhoods. The packet contains the following sections: (1) Mental Health in Schools: An Overview; (2) Executive Summary--Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations; (3) Impediments to Enhancing Availability of Mental Health Services on Schools: Fragmentation, Overspecialization, Counterproductive Competition, and Marginalization; (4) Mental Health in Schools: A Sampling of References; and (5) Assuring No Child Is Left Behind: Strengthening the Approach of School and Community for Addressing Barriers to Student Learning. (GCP)

Reproductions supplied by EDRS are the best that can be made
from the original document.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

P Nelson

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

1

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED 463 509

Mental Health in Schools Training and Technical Assistance Center

From the Center's Clearinghouse ...*

An Introductory packet

About Mental Health in Schools

April, 2002

This document is a hardcopy version of a resource that can be downloaded at no cost from the Center's website (http://smhp.psych.ucla.edu). The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA. Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563 (310) 825-3634 Fax: (310) 206-8716; E-mail: smhp@ucla.edu

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

CG031678

BEST COPY AVAILABLE

About Mental Health in Schools

One of the most frequently asked questions received by our Center is:

What does the term Mental Health in Schools mean?

To provide an overview of what the term means, the Center for Mental Health in Schools at UCLA has compiled a subset of its resources and highlighted the documents on its website (click on the icon on the Center's home page). Included on the website are:

- A brief introduction, entitled Mental Health in Schools: An Overview
- A field-defining resource and reference work entitled: Mental Health in Schools: Guidelines, Models, Resources & Policy Considerations
- Linkage to a paper by Adelman and Taylor commissioned by NASP and ERIC/CASS entitled: Impediments to Enhancing Availability of Mental Health Services in Schools: Fragmentation, Overspecialization, Counterproductive Competition, and Marginalization
- Mental Health in Schools - A Sampling of References (from the Center's Quick Find Collection)
- A Center policy tool entitled: New Directions for School & Community Initiatives to Address Barriers to Learning: Two Examples of Concept Papers to Inform and Guide Policy Makers.
- A brief overview about our Center and the work we do.

Some of the above resources are compiled here for your convenience. You can review and download the rest from the Center website.

Given the evolving nature of the field, we hope you will send us your ideas for enhancing the material and content of what is presented here.

Howard Adelman & Linda Taylor
Center, Co-directors

CONTENTS

- Mental Health in Schools: An Overview

- Executive Summary – Mental Health in Schools: Guidelines, Models, Resources & Policy Considerations

- Impediments to Enhancing Availability of Mental Health Services in Schools: Fragmentation, Overspecialization, Counterproductive Competition, and Marginalization

- Mental Health in Schools - A Sampling of References (from the Center's Quick Find Collection)

- Assuring No Child is Left Behind: Strengthening the Approach of School and Community for Addressing Barriers to Student Learning (example of a concept paper drafted for an urban school district)

- A brief overview about our Center and the work we do.

Mental Health in Schools: An Overview

Why mental health in schools?

It is, of course, not a new insight that physical and mental health concerns must be addressed if schools are to function satisfactorily and students are to succeed at school. It has long been acknowledged that a variety of psychosocial and health problems affect learning and performance in profound ways. Such problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure. Because of all this, school policy makers, have a lengthy (albeit somewhat reluctant) history of trying to assist teachers in dealing with problems that interfere with schooling. Prominent examples are seen in the range of counseling, psychological, and social service programs schools provide.

Adding to what school education support staff do, there has been renewed emphasis over the past 20 years in the health and social services arenas on increasing linkages between schools and community service agencies to enhance the well-being of young people and their families. This "school-linked services" agenda has added impetus to advocacy for mental health in schools.

More recently, the efforts of some advocates for school-linked services has merged with forces working to enhance initiatives for community schools, youth development, and the preparation of healthy and productive citizens and workers. The merger has expanded interest in social-emotional learning and protective factors as avenues to increase students' assets and resiliency and reduce risk factors.

Thus, varied policies and initiatives have emerged relevant to efforts to enhance mental health in schools. Some directly support school programs and personnel; others connect community programs and personnel with schools. As a result, most schools have some programs to address a range of mental health and psychosocial concerns (e.g., school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, delinquency, violence.)

School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. And, available research suggests that for some youngsters schools are the main providers of mental health services. As Burns and her colleagues report from the study of children's utilization of MH services in western North Carolina, "the major player in the de facto system of care was the education sector – more than three-fourths of children receiving mental health services were seen in the education sector, and for many this was the sole source of care."

Advancing mental health in schools

Clearly, mental health activity is going on in schools. Equally evident, there is a great deal to be done to improve what is taking place. The current norm related to efforts to advance mental health policy is for a vast sea of advocates to compete for the same dwindling resources. This includes advocates representing different professional practitioner groups. Naturally, all such advocates want to advance their agenda. And, to do so, the temptation usually is to keep the agenda problem-focused and rather specific and narrow. Politically, this make some sense. But in the long-run, it may be counterproductive in that it fosters piecemeal, fragmented, and redundant policies and practices. Diverse school and community resources are attempting to address complex, multifaceted, and overlapping psychosocial and mental health concerns in highly fragmented and marginalized ways. This has led to redundancy, inappropriate competition, and inadequate results.

One response to this state of affairs is seen in the calls for realigning policy and practice around a cohesive framework based on well-conceived models and the best available scholarship. With specific respect to mental health in schools, it has been stressed that initiatives must connect in major ways with the mission of schools and integrate with a restructured system of education support programs and services.

From our perspective, it is time to take a close look at all the pieces. To date, there has been no comprehensive mapping and no overall analysis of the amount of resources used for efforts relevant to mental health in schools or of how they are expended. Without such a "big picture" analysis, policymakers and practitioners are deprived of information that is essential in determining equity and enhancing system effectiveness. The challenge for those focused on mental health in schools is not only to understand the basic concerns hampering the field, but to function on the cutting edge of change so that the concerns are effectively addressed.

Systemic changes must weave school owned resources and community owned resources together to develop comprehensive, multifaceted, and integrated approaches for addressing barriers to learning and enhancing healthy development. Moreover, pursuit of such changes also must address complications stemming from the scale of public education in the U.S.A. Currently, there are about 90,000 public schools in about 15,000 districts. Thus, efforts to advance mental health in schools also must adopt effective models and procedures for replication and "scale-up."

Needed: Strategic approaches & comprehensive frameworks to enhance policy & practice

Although efforts to advance mental health in schools often are hampered by competing initiatives and agendas, the diversity of initiatives has laid a foundation that can be built upon. There is a need, however, for increased emphasis on *strategic* approaches for enhancing policy and practice. Such strategic approaches can be fostered through efforts to unify thinking about mental health in schools, adoption of well-conceived guiding frameworks, and by support for development of focused networking. To these ends, the Center for Mental Health in Schools at UCLA (1) highlights the need for a broad perspective in thinking about and justifying "mental health" in schools, (2) promotes a working draft of comprehensive and multifaceted guidelines that provide a basis for operationally defining mental health in schools, (3) proposes an integrated framework for promoting healthy development and addressing barriers to learning at a school site in ways that can expand the impact of mental health in schools, and (4) pursues a wide variety of strategies designed to advance the field.

Ending the marginalization

Clearly, enhancing mental health in schools in comprehensive ways is not an easy task. Indeed, it is likely to remain an insurmountable task until school reformers accept the reality that such activity is essential and does not represent an agenda separate from a school's instructional mission. For this to happen, we must encourage them to view the difficulty of raising achievement test scores through the complementary lenses of addressing barriers to learning and promoting healthy development. When this is done, it is more likely that mental health in schools will be understood as essential to addressing barriers to learning and not as an agenda separate from a school's instructional mission.

Then, we must show how all policy, practice, and research related to mental health in schools, including the many categorical programs funded to deal with designated problems, can be woven into a cohesive continuum of interventions and integrated thoroughly with school reform efforts. In the process, we will need to stress the importance of school-community-home collaborations in weaving together the resources for comprehensive, multifaceted approaches.

In sum, advancing mental health in schools is about much more than expanding services and creating full service schools. It is about establishing comprehensive, multifaceted approaches that help ensure schools are caring and supportive places that maximize learning and well-being and strengthen students, families, schools, and neighborhoods.

Policy Leadership Cadre for Mental Health in Schools*

Executive Summary

Mental Health in Schools: Guidelines, Models, Resources, & Policy Considerations

May, 2001

UCLA Mental Health in Schools Center Training and Technical Assistance

*The document was developed by the *Policy Leadership Cadre for MH in Schools*.
The work of the Cadre is facilitated by the national Center for Mental Health in Schools which operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 Phone: (310) 825-3634.

This document can be downloaded from the webpages for the Cadre which currently are hosted on the Center's website – go to http://smhp.psych.ulca.edu – click on Contents, scroll down to Center Hosted Sites and click on the Cadre entry. Hard copies of this document are available from the Center.

Support comes in part from the U.S. Dept. of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health, with co-funding from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services

U.S. Department of Health and Human Services HRSA Health Resources and Services Administration Maternal and Child Health Bureau

CMHS Center for Mental Health Services SAMHSA Substance Abuse & Mental Health Services Administration

Executive Summary:

Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations

What is meant by the term mental health in schools?

Ask five people and you'll probably get five different answers.

That is why so many leaders in the field have called for clarification of what mental health (MH) in schools is and is not. Toward these ends, the *Policy Leadership Cadre for Mental Health in Schools* has developed the resource and reference document summarized here.* The focus of the work is on:

- definitional concerns
- the rationale for mental health in schools
- a set of guidelines to clarify the nature and scope of a comprehensive, multifaceted approach
- the ways in which mental health and psychosocial concerns currently are addressed in schools
- advancing the field.

To embellish the document's value as a resource aid for policy and capacity building, a variety of supportive documents and sources for materials, technical assistance, and training are provided.

Concerns . . .

about definition

As is widely recognized, there is a tendency to discuss mental *health* mainly in terms of mental illness, disorders, or problems. This de facto definition has led school policy makers to focus primarily on concerns about emotional disturbance, violence, and substance abuse and to deemphasize the school's role in the positive development of social and emotional functioning. The guidelines presented in this document are meant to redress this tendency. They stress that the definition of MH in schools should encompass the promotion of social and emotional development (i.e., positive MH) and efforts to address psychosocial and MH problems as major barriers to learning.

and

the place of MH in schools

Among some segments of the populace, schools are not seen as an appropriate venue for MH interventions. The reasons vary from concern that such activity will take time away from the educational mission to fear that such interventions are another attempt of society to infringe on family rights and values. There also is the long-standing discomfort so many in the general population feel about the subject of mental health because it so often is viewed only in terms of mental illness. And, there is a historical legacy of conflict among various stakeholders stemming from insufficiently funded legislative mandates that have produced administrative, financial, and legal problems for schools and problems of access to entitled services for some students.

Whatever one's position about MH in schools, we all can agree on one simple fact: *schools are not in the mental health business.* Education is the mission of schools, and policymakers responsible for schools are quick to point this out when they are asked to do more about physical and mental health. It is not that they disagree with the idea that healthier students learn and perform better. It is simply that prevailing school accountability pressures increasingly have concentrated policy on instructional practices – to the detriment of all matters not seen as *directly* related to raising achievement test scores.

Rationale

Given these realities, as a general rationale for MH in schools, we begin with the view of the Carnegie Council Task Force on Education of Young Adolescents (1989) which states:

> *School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.*

It is, of course, not a new insight that physical and mental health concerns must be addressed if schools are to function satisfactorily and students are to learn and perform effectively. It has long been acknowledged that a variety of psychological and physical health problems affect learning in profound ways. Moreover, these problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure.

Despite some reluctance, school policy makers have a long-history of trying to assist teachers in dealing with problems that interfere with school learning. Prominent examples are seen in the range of counseling, psychological, and social service programs provided by schools. Similarly, policymakers in other arenas have focused on enhancing linkages between schools and community service agencies and other neighborhood resources. Paralleling these efforts is a natural interest in promoting healthy and productive citizens and workers. This is especially evident in initiatives for enhancing students' assets and resiliency and reducing risk factors through an emphasis on social-emotional learning and protective factors.

Guidelines

Based on a set of underlying principles and some generic guidelines for designing comprehensive, multifaceted, and cohesive approaches to MH in schools, the following set of guidelines is presented along with rationale statements and references related to each guideline. Clearly, no school currently offers the nature and scope of what is embodied in the outline. In a real sense, the guidelines define a vision for how MH in schools should be defined and implemented.

GUIDELINES FOR MENTAL HEALTH IN SCHOOLS

1. General Domains for Intervention in Addressing Students' Mental Health

1.1 Ensuring academic success and also promoting healthy cognitive, social, and emotional development and resilience (including promoting opportunities to enhance school performance and protective factors; fostering development of assets and general wellness; enhancing responsibility and integrity, self-efficacy, social and working relationships, self-evaluation and self-direction, personal safety and safe behavior, health maintenance, effective physical functioning, careers and life roles, creativity)

1.2 Addressing barriers to student learning and performance (including educational and psychosocial problems, external stressors, psychological disorders)

1.3 Providing social/emotional support for students, families, and staff

2. *Major Areas of Concern Related to Barriers to Student Learning*

2.1 Addressing common educational and psychosocial problems (e.g., learning problems; language difficulties; attention problems; school adjustment and other life transition problems; attendance problems and dropouts; social, interpersonal, and familial problems; conduct and behavior problems; delinquency and gang-related problems; anxiety problems; affect and mood problems; sexual and/or physical abuse; neglect; substance abuse; psychological reactions to physical status and sexual activity)

2.2 Countering external stressors (e.g., reactions to objective or perceived stress/demands/ crises/deficits at home, school, and in the neighborhood; inadequate basic resources such as food, clothing, and a sense of security; inadequate support systems; hostile and violent conditions)

2.3 Teaching, serving, and accommodating disorders/disabilities (e.g., Learning Disabilities; Attention Deficit Hyperactivity Disorder; School Phobia; Conduct Disorder; Depression; Suicidal or Homicidal Ideation and Behavior; Post Traumatic Stress Disorder; Anorexia and Bulimia; special education designated disorders such as Emotional Disturbance and Developmental Disabilities)

3. *Type of Functions Provided related to Individuals, Groups, and Families*

3.1 Assessment for initial (first level) screening of problems, as well as for diagnosis and intervention planning (including a focus on needs and assets)

3.2 Referral, triage, and monitoring/management of care

3.3 Direct services and instruction (e.g., primary prevention programs, including enhancement of wellness through instruction, skills development, guidance counseling, advocacy, school-wide programs to foster safe and caring climates, and liaison connections between school and home; crisis intervention and assistance, including psychological first-aid; prereferral interventions; accommodations to allow for differences and disabilities; transition and follow-up programs; short- and longer- term treatment, remediation, and rehabilitation)

. 3.4 Coordination, development, and leadership related to school-owned programs, services, resources, and systems – toward evolving a comprehensive, multifaceted, and integrated continuum of programs and services

3.5 Consultation, supervision, and inservice instruction with a transdisciplinary focus

3.6 Enhancing connections with and involvement of home and community resources

(including but not limited to community agencies)

(cont.)

Guidelines For Mental Health in Schools **(cont.)**

4. ***Timing and Nature of Problem-Oriented Interventions***

4.1 Primary prevention
4.2 Intervening early after the onset of problems
4.3 Interventions for severe, pervasive, and/or chronic problems

5. ***Assuring Quality of Intervention***

5.1 Systems and interventions are monitored and improved as necessary
5.2 Programs and services constitute a comprehensive, multifaceted continuum
5.3 Interveners have appropriate knowledge and skills for their roles and functions and provide guidance for continuing professional development
5.4 School-owned programs and services are coordinated and integrated
5.5 School-owned programs and services are connected to home & community resources
5.6 Programs and services are integrated with instructional and governance/management components at schools
5.7 Program/services are available, accessible, and attractive
5.8 Empirically-supported interventions are used when applicable
5.9 Differences among students/families are appropriately accounted for (e.g., diversity, disability, developmental levels, motivational levels, strengths, weaknesses)
5.10 Legal considerations are appropriately accounted for (e.g., mandated services; mandated reporting and its consequences)
5.11 Ethical issues are appropriately accounted for (e.g., privacy & confidentiality; coercion)
5.12 Contexts for intervention are appropriate (e.g., office; clinic; classroom; home)

6. ***Outcome Evaluation and Accountability***

6.1 Short-term outcome data
6.2 Long-term outcome data
6.3 Reporting to key stakeholders and using outcome data to enhance intervention quality

---

What schools are already doing

Currently, there are almost 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of mental health and psychosocial concerns in mind. And, there is a large body of research supporting the promise of many of the approaches schools are pursuing.

School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development (see the next page for an Exhibit highlighting five major *delivery mechanisms and formats*). Despite the range of activity, it remains the case that too little is being done in most schools, and prevailing approaches are poorly conceived and are implemented in fragmented ways.

Delivery Mechanisms and Formats

The five mechanisms and related formats are:

1. ***School-Financed Student Support Services*** – Most school districts employ pupil services professionals such as school psychologists, counselors, and social workers to perform services related to mental health and psychosocial problems (including related services designated for special education students). The format for this delivery mechanism tends to be a combination of centrally-based and school-based services.

2. ***School-District Mental Health Unit*** – A few districts operate specific mental health units that encompass clinic facilities, as well as providing services and consultation to schools. Some others have started financing their own School-Based Health Centers with mental health services as a major element. The format for this mechanism tends to be centralized clinics with the capability for outreach to schools.

3. ***Formal Connections with Community Mental Health Services*** – Increasingly, schools have developed connections with community agencies, often as the result of the school-based health center movement, school-linked services initiatives (e.g., full service schools, family resource centers), and efforts to develop systems of care ("wrap-around" services for those in special education). Four formats have emerged:

   - co-location of community agency personnel and services at schools – sometimes in the context of School-Based Health Centers partly financed by community health orgs.
   - formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center
   - formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services
   - contracting with community providers to provide needed student services

4. ***Classroom-Based Curriculum and Special "Pull Out" Interventions*** – Most schools include in some facet of their curriculum a focus on enhancing social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms always are supposed to have a constant focus on mental health concerns. Three formats have emerged:

   - integrated instruction as part of the regular classroom content and processes
   - specific curriculum or special intervention implemented by personnel specially trained to carry out the processes
   - curriculum approach is part of a multifaceted set of interventions designed to enhance positive development and prevent problems

5. ***Comprehensive, Multifaceted, and Integrated Approaches*** – A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They are starting to restructure their student support services and weave them together with community resources and integrate all this with instructional efforts that effect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens. Mental health and psychosocial concerns are a major focus of the continuum of interventions. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:

   - mechanisms to coordinate and integrate school and community services
   - initiatives to restructure student support programs and services and integrate them into school reform agendas
   - community schools

continuum of interventions. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:

- mechanisms to coordinate and integrate school and community services
- initiatives to restructure student support programs and services and integrate them into school reform agendas
- community schools

The document concludes with a discussion of policy-focused ideas related to advancing the field. At present, a low policy priority is assigned to addressing mental health and psychosocial factors that negatively affect youngsters development and learning. In schools, existing programs are characterized as supplemental services and are among the first to go when budgets become tight. In effect, they are marginalized in policy and practice. For this situation to change, greater attention must be paid to enhancing the policy priority assigned such matters, developing integrated infrastructures including new capacity building mechanisms, enhancing use of available resources, and rethinking the roles, functions, and credentialing of pupil service personnel.

Concluding Comments

In terms of policy, practice, and research, all activity related to MH in schools, including the many categorical programs funded to deal with designated problems, eventually must be seen as embedded in a cohesive continuum of interventions and integrated thoroughly with school reform efforts.

When this is done, MH in schools will be viewed as essential to addressing barriers to learning and not as an agenda separate from a school's instructional mission.

In turn, this will facilitate establishment of school-community-home collaborations and efforts to weave together all activity designed to address mental health problems and other barriers to learning.

All this can contribute to the creation of caring and supportive environments that maximize learning and well-being and strengthen students, families, schools, and neighborhoods.

Impediments to Enhancing Availability of Mental Health Services in Schools:
Fragmentation, Overspecialization, Counterproductive Competition, and Marginalization

Howard Adelman & Linda Taylor

Abstract

Concerns about enhancing availability and access to mental health services in schools range from sparse resources to the proliferation of piecemeal and overspecialized interventions arising from categorical funding. This paper discusses such concerns and stresses that they must be addressed from a perspective that fully appreciates the degree to which school policies and practices marginalize student support programs and services. Changing all this is discussed in terms of reframing school reform to fully address barriers to student learning. Finally, a proactive agenda addressing the implications for new directions for pupil personnel professionals is suggested.

Note: This paper introduces a new phase in the NASP-ERIC/CASS Partnership. Each year NASP and ERIC/CASS will commission an outstanding author to prepare an original paper relevant to the theme of the NASP national convention. This paper will be presented to the NASP Executive Council and later made available to NASP members at the ERIC/CASS booth at the convention. In recognition of its special status, the paper will be entered into the ERIC international database as an ERIC/CASS - NASP Premier Partnership Paper. This category will be reserved for papers displaying the highest order of scholarship and devoted to a topic of compelling criticality for school psychology. It will also be posted on the websites of both organizations.

This paper, *Impediments to Enhancing Availability of Mental Health Services in Schools: Fragmentation, Overspecialization, Counterproductive Competition, and Marginalization*, authored by two eminent policy strategists, Howard S. Adelman and Linda Taylor, is an excellent start-up for the series and appropriately compliments the convention theme of Overcoming Barriers, Increasing Access and Serving All Children. It is our joint intent that this paper will highlight the high quality of resources being entered into the ERIC database and also encourage other psychologists to submit their papers to ERIC/CASS.

Susan Gorin, CAE
Executive Director
NASP

Garry R. Walz, PhD, NCC
Co-Director
ERIC/CASS

Impediments to Enhancing Availability of Mental Health Services in Schools:

Fragmentation, Overspecialization, Counterproductive Competition, and Marginalization

Howard Adelman & Linda Taylor

Over the years, various legal mandates and awareness of the many barriers to learning have given rise to a variety of school counseling, psychological, and social support programs and to initiatives for school-community collaborations. Paralleling these efforts is a natural interest in promoting healthy development. As a result, a great amount of activity is in play, and a great many concerns have arisen about intervention availability, access, and delivery and about effectiveness and cost-efficiency.

Much has been made of categorical funding as related to the problems of availability and access and the proliferation of piecemeal and overspecialized interventions. Concomitantly, problems constantly arise because of turf battles among pupil service personnel and between such personnel and community providers offering school-linked services. Such concerns clearly are significant and related. However, they need to be addressed from a perspective that fully appreciates the degree to which programs and services for addressing barriers to student learning are marginalized in school policy and practice. This paper discusses such concerns and the need to reframe school reform and the roles of pupil personnel professionals in order to deal with them.

Fragmentation, Overspecialization, and Competition

Problems of fragmentation, overspecialization, and counterproductive competition arise from several sources. For purposes of this discussion, it will suffice to highlight matters in terms of efforts related to (a) school-owned programs and (b) initiatives designed to enhance school and community agency connections.

School-Owned Programs

Looked at as a whole, one finds in many school districts a range of preventive and corrective activity oriented to students' needs and problems. Some programs are provided throughout a school district, others are carried out at or linked to targeted schools. (Most are owned and operated by schools; some are owned by community agencies.) The interventions may be offered to all students in a school, to those in specified grades, to those identified as "at risk," and/or to those in need of compensatory education. The activities may be implemented in regular or special education classrooms and may be geared to an entire class, groups, or individuals; or they may be designed as "pull out" programs for designated students. They encompass ecological, curricular, and clinically oriented activities designed to reduce problems such as substance abuse, violence, teen pregnancy, school dropouts, and delinquency (Adelman, 1996a).

It is common knowledge, however, that few schools come close to having enough resources when confronted with a large number of students experiencing a wide range of psychosocial barriers that interfere with learning and performance. Most schools offer only bare essentials.
Too many schools cannot even meet basic needs. Primary prevention often is only a dream.

While schools can use a variety of persons to help students, most school-owned and operated services are offered as part of what are called pupil personnel services or support services. Federal and state mandates tend to determine how many pupil service professionals are employed, and states regulate compliance with mandates. Governance of daily practice usually is centralized at the school district level. In large districts, psychologists, counselors, social workers, and other specialists may be organized into separate units. Such units overlap regular, special, and compensatory education. Analyses of the situation find that the result is programs and services that have a specialized focus and relative autonomy. Thus, although they usually must deal with the same common barriers to learning (e.g., poor instruction, lack of parent involvement, violence and unsafe schools, inadequate support for student transitions), the programs and services generally are planned, implemented, and evaluated in a fragmented and piecemeal manner. Consequently, student support staff at schools tend to function in relative isolation of each other and other stakeholders, with a great deal of the work oriented to discrete problems and with an overreliance on specialized services for individuals and small groups. In some schools, a student identified as at risk for grade retention, dropout, and substance abuse may be assigned to three counseling programs operating independently of each other. Such fragmentation not only is costly, it works against developing cohesiveness and maximizing results, and it leads to counterproductive competition for sparse resources - all of which works against enhancing availability (Adelman, 1996a; Adelman & Taylor, 1997, 1999).

Furthermore, in every facet of a school district's operations, an undesirable separation usually is manifested among the instructional and management components and the various activities that constitute efforts to address barriers to learning. At the school level, this translates into situations where teachers simply do not have the supports they need when they identify students who are having difficulties. Clearly, prevailing school reform processes and capacity building (including pre and in service staff development) have not dealt effectively with such concerns.

School-Community Collaborations

As another way to provide more support for schools, students, and families, there has been increasing interest in school-community collaborations. This interest is bolstered by the renewed policy concern about countering widespread fragmentation of and enhancing availability and access to community health and social services and by the various initiatives for school reform, youth development, and community development. In response to growing interest and concern, various forms of school-community collaborations are being tested, including state-wide initiatives in many states (e.g., California, Florida, Kentucky, Missouri, New Jersey, Ohio, and Oregon). This movement has fostered such concepts as school linked services, coordinated services, wrap-around services, one-stop shopping, full service schools, and community schools (Dryfoos, 1994). The growing youth development movement adds concepts such as promoting protective factors, asset-building, wellness, and empowerment.

In building school-community collaborations, the tendency has been to limit thinking about communities by focusing only on agencies. This is unfortunate because the range of resources in a community is much greater than the service agencies and community-based organizations that often are invited to the table (Kretzmann & McKnight, 1993).

Not surprisingly, early findings primarily indicate how challenging it is to establish collaborations (Knapp, 1995; Melaville & Blank, 1998; SRI, 1996; White & Whelage, 1995). Still, a reasonable inference from available data is that school-community collaborations can be successful and cost effective over the long-run. For example, by placing staff at schools,

community agencies increase the amount of assistance available and make access easier for students and families, especially those who usually are underserved and hard to reach. Such efforts not only provide services, they seem to encourage schools to open their doors in ways that enhance recreational, enrichment, and remedial opportunities, and lead to greater family involvement (Center for Mental Health in Schools, 1996, 1997; Day & Roberts,1991; Dryfoos, 1994, 1998; Knapp, 1995; Lawson & Briar-Lawson, 1997; Melaville & Blank, 1998; Schorr, 1997; Taylor & Adelman, 2000; U.S. Department of Education, 1995; U.S. General Accounting Office, 1993).

Marginalization

Policy makers have come to appreciate the relationship between limited intervention effectiveness and the widespread tendency for complementary programs in school and community to operate in isolation. Limited results do seem inevitable as long as interventions are carried out in a piecemeal and inappropriately competitive fashion and with little follow through.

The call for "integrated services" clearly is motivated by the desire to reduce redundancy, waste, and ineffectiveness resulting from fragmentation, while also increasing availability and access (Adler & Gardner, 1994; Merseth, Schoor, & Elmore, 2000). Special attention is given to the many piecemeal, categorically funded approaches, such as those created to reduce learning and behavior problems, substance abuse, violence, school dropouts, delinquency, and teen pregnancy. However, by focusing primarily on fragmentation, policy makers fail to deal with the overriding issue, namely that addressing barriers to development and learning remains a marginalized aspect of policy and practice. Fragmentation stems from the marginalization, but concern about such marginalization is not even on the radar screen of most policy makers.

Stated simply, the majority of school programs, services, and special projects designed to address barriers to student learning are viewed as supplementary (often referred to as auxiliary services) and operate on an ad hoc basis. The degree to which marginalization is the case is seen in the lack of attention given to such school activity in consolidated plans and certification reviews and the lack of efforts to map, analyze, and rethink how resources are allocated. Educational reformers virtually have ignored the need to reframe and restructure the work of school professionals who carry out psychosocial and health programs. As long as this remains the case, reforms to reduce fragmentation and increase availability and access are seriously hampered. More to the point, the desired impact for large numbers of children and adolescents will not be achieved.

At most schools, community involvement also is a marginal concern, and the trend toward fragmentation is compounded by most school-linked services' initiatives. This happens because such initiatives focus primarily on coordinating community services and linking them to schools, with an emphasis on co-locating rather than integrating such services with the ongoing efforts of school staff. Fragmentation is worsened by the failure of policy makers at all levels to recognize these problems (Adelman & Taylor, 2000). Reformers mainly talk about "school-linked integrated services" – apparently in the belief that a few health and social services are a sufficient response. Such talk has led some policy makers to the mistaken impression that community resources alone can effectively meet the needs of schools in addressing barriers to learning. In turn, this has led some legislators to view linking community services to schools as a way to free the dollars underwriting school-owned services. The reality is that even when one adds together community and school assets, the total set of services in impoverished locales is woefully inadequate. In situation after situation, it has become evident that as soon as the first few sites demonstrating school-community collaboration are in place, community agencies find they have

stretched their resources to the limit. Another problem is that the overemphasis on school-linked services is exacerbating rising tensions between school district service personnel and their counterparts in community- based organizations. As "outside" professionals offer services at schools, school specialists often view the trend as discounting their skills and threatening their jobs. At the same time, the "outsiders" often feel unappreciated and may be rather naive about the culture of schools. Turf conflicts arise over use of space, confidentiality, and liability. Thus, a counterproductive competition rather than a substantive commitment to collaboration is the norm.

In short, policies shaping agendas for school and community reform are seriously flawed. Although fragmentation and access are significant problems, marginalization is of greater concern. It is unlikely that the problems associated with education support services will be appropriately resolved in the absence of concerted attention in policy and practice to ending the marginalized status of efforts to address factors interfering with development, learning, parenting, and teaching.

Reframing School Reform to Fully Address Barriers to Student Learning

Keys to ending marginalization include expanding comprehensiveness and ensuring that school reform initiatives fully integrate education support activity. Presently, there are several windows of opportunity for moving in this direction.

Windows of Opportunity for Systemic Change and Renewal

Among the most prominent opportunities are the major reform initiatives related to schools and welfare and health services. These initiatives are shifting the ways in which children and their families interface with school and community. For example, among other things, school reform aims to close the achievement gap, eliminate social promotion, enhance school safety, and minimize misindentification and maximize inclusion of exceptional learners in regular programs (Center for Mental Health in Schools, 2001a; Lipsky & Gartner, 1996). If such changes are to benefit the targeted students, current implementation strategies must be thoroughly overhauled, and well-designed interventions for prevention and early-after-onset correction of problems are essential. To these ends, all school personnel concerned with these matters must find their way to leadership tables so that effective system-wide changes are designed and implemented.

Similar opportunities arise around welfare reform. As the pool of working parents is increased, there is an expanding need for quality day care and preschool programs and programs to fill nonschool hours for all youngsters. Health reforms also are beginning to bring more services to schools (e.g., school-based health centers, family resource centers) and are stimulating renewed interest in primary and secondary prevention. As local schools and neighborhoods wrestle with the implications of all this, the result can be further fragmentation and marginalization of programs, or steps can be taken to weave changes into comprehensive approaches for addressing barriers to development and learning. Student support staff have not yet emerged as key participants in these arenas, but the opportunity for assuming a leadership role is there.

Another window of opportunity comes from the rapid expansion of technology. In the next few years, technology will provide major avenues for improving how school staff function. Now is the time to take the lead in planning how technology will be used in working with students and their families and in building capacity for more effective, less costly interventions. Tools already are available for empowering student choice and self-sufficiency and system capacity building. Improved computer programs are emerging that systematically support many

intervention activities, and the Internet enables increased access to information and resources, enhances collaborative efforts including consultation and networking, and provides personalized continuing education and distance learning (Center for Mental Health in Schools, 2000). Resources contained in ERIC and the ERIC/CASS Virtual Libraries can be highly contributive to the efforts to reframe school reform and address barriers to student learning (http://ericcass.uncg.edu).

Toward Comprehensive, Multifaceted Approaches

Prevailing initiatives and windows of opportunity provide a context for formulating next steps and new directions. Building on what has gone before, we submit the following propositions. First, we suggest that many specific problems are best pursued as an integrated part of a comprehensive, multifaceted continuum of interventions designed to address barriers to learning and promote healthy development. For another, we submit that comprehensive, multifaceted approaches are only feasible if the resources of schools, families, and communities are woven together. A corollary of this is that the committed involvement of school, family, and community is essential in maximizing intervention implementation and effectiveness. The following discussion is designed to clarify these propositions.

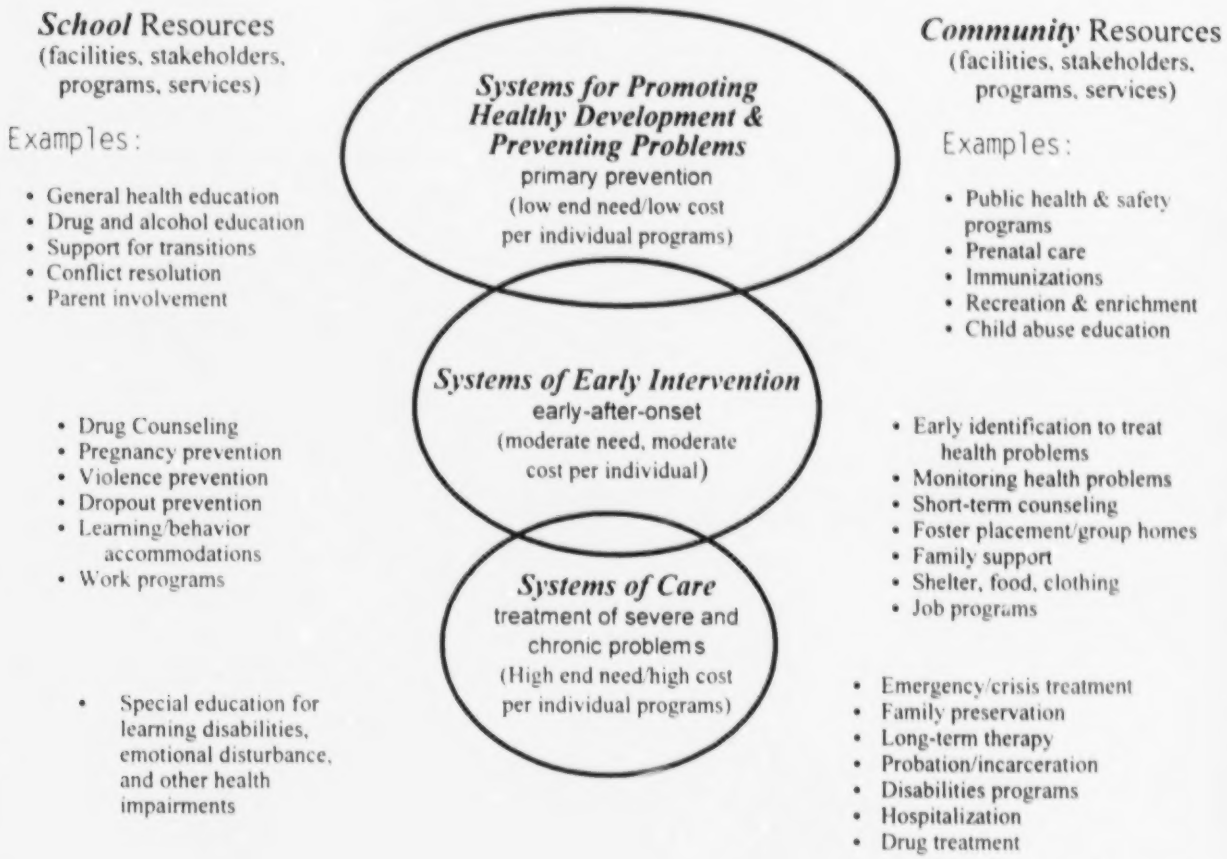
A comprehensive and multifaceted continuum of braided interventions. Problems experienced by students generally are complex in terms of cause and needed intervention. This means interventions must be comprehensive and multifaceted.

How comprehensive and multifaceted? The desired interventions can be conceived as a continuum ranging from a broad-based emphasis on promoting healthy development and preventing problems (both of which include a focus on wellness or competence enhancement) through approaches for responding to problems early-after-onset, and extending on to narrowly focused treatments for severe/chronic problems (see Figure). Not only does the continuum span the concepts of primary, secondary, and tertiary prevention, it can incorporate a holistic and developmental emphasis that envelops individuals, families, and the contexts in which they live, work, and play. The continuum also provides a framework for adhering to the principle of using the least restrictive and nonintrusive forms of intervention required to appropriately respond to problems and accommodate diversity.

Moreover, given the likelihood that many problems are not discrete, the continuum can be designed to address root causes, thereby minimizing tendencies to develop separate programs for each observed problem. In turn, this enables increased coordination and integration of resources which can increase impact and cost-effectiveness. Ultimately, the continuum can evolve into integrated systems by enhancing the way the interventions are connected. Such connections may involve horizontal and vertical restructuring of programs and services (a) within jurisdictions, school districts, and community agencies (e.g., among divisions, units) and (b) between jurisdictions, school and community agencies, public and private sectors, among clusters of schools, and among a wide range of community resources.

Integrating with school reform. It is one thing to stress the desirability of developing a full continuum of interventions; it is quite another to propose that schools should be involved in doing so. In the long run, the success of such proposals probably depends on anchoring them in the mission of schools. That is, the recommendations must be rooted in the reality that

Figure. Interconnected systems for meeting the needs of all students.



Systemic collaboration* is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among *systems* of *prevention, systems* of *early intervention*, and *systems of care*.

*Such collaboration involves horizontal and vertical restructuring of programs and services
(a) within jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools)
(b) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies

Adapted from various public domain documents authored by H. S. Adelman & L. Taylor and circulated through the Center for Mental Health in Schools at UCLA.

schools are first and foremost accountable for educating the young. In particular, such proposals must reflect an appreciation that schools tend to become concerned about addressing a problem when it clearly is a barrier to student learning. Moreover, it is the entire constellation of external and internal barriers to learning that argues for schools, families, and communities working together to develop a cohesive, comprehensive, multifaceted approach. Indeed, to achieve their educational mission, schools need to address barriers to learning and to do so with more than school-linked, integrated health and human services. Addressing barriers involves comprehensive, multifaceted strategies that can only be achieved through strong school-community connections. (School-community connections are particularly important in poverty areas where schools often are the largest piece of public real estate in the community and also may be the single largest employer.)

As stressed above, however, the current situation is one where schools marginalize everything except direct efforts to improve teaching and enhance the way schools are managed. Therefore, we suggest that policy makers must move beyond what fundamentally is a two-component model dominating school reform. They must recognize that for teachers to teach effectively there must not only be effective instruction and well-managed schools; there also must be a component to address barriers in a comprehensive way.

Enabling Learning by Addressing Barriers

Our work points to the need for a three-component framework for reform that views all three components as complementary and overlapping (Adelman, 1996a; 1996b; Adelman & Taylor, 1994, 1997, 1998; Center for Mental Health in Schools, 1996,1997, 1998). The third component is conceived as a comprehensive, multifaceted approach to enable learning by addressing barriers. Thus, we call it an enabling component. (Enabling is defined as "providing with the means or opportunity; making possible, practical, or easy.") Of even greater importance, we have stressed that adoption of a three-component model must be done in a way that elevates efforts to address barriers to development, learning, and teaching to the level of a fundamental and essential facet of education reform and school and community agency restructuring.

By calling for reforms that fully integrate a focus on addressing barriers to learning, the concept of an enabling component provides a unifying frame of reference for responding to a wide range of psychosocial factors interfering with effective schooling. In policy and practice, all categorical programs, such as Title I, safe and drug free school programs, and special education, can be integrated into such a comprehensive component. Moreover, when current policy and practice are viewed through the lens of this third component, it becomes evident how much is missing in prevailing efforts to enable learning, development, and teaching. Adoption of such an inclusive unifying concept is seen as pivotal in convincing policy makers to recognize the essential nature of activity to enable learning. That is, the third component is seen as providing both a basis for combating marginalization and a focal point for developing a comprehensive framework for policy and practice. When such a component is elevated to a high policy level, it finally will be feasible to unify disparate approaches to preventing and ameliorating psychosocial problems and promoting wellness, thereby reducing fragmentation. That is, we see this form of expanded school reform as a foundation upon which to mesh resources for minimizing risk factors and fostering healthy development and as a catalyst for rethinking community resources and how they can best be connected with schools.

Implications for New Directions for Pupil Personnel Professionals: A Proactive Agenda

Our analyses envision schools and communities weaving their resources together to develop a comprehensive continuum of programs and services designed to address barriers to development, learning, parenting, and teaching. From a decentralized perspective, the primary focus in designing such an approach is on systemic changes at the school and neighborhood level. Then, based on understanding what is needed to facilitate and enhance local efforts, changes must be made for families of schools and wider communities. Finally, with clarity about what is needed to facilitate school and community-based efforts and school-community

partnerships, appropriate centralized restructuring can be pursued.

Whether or not what we envision turns out to be the case, pupil service personnel must be proactive in shaping their future. In doing so, they must understand and take advantage of the windows of opportunity that are currently open as a result of major reform initiatives and the rapid advances in technology. We also think they need to adopt an expanded vision of their roles and functions (Policy Leadership Cadre for Mental Health in Schools, 2001). Politically, they must integrate themselves fully into school reform at all levels and especially at the school.

For some time, policy and practice changes have suggested the need for restructuring personnel roles and functions and systemic mechanisms (at schools, in central offices, and by school boards). Some thoughts about this are offered in the next section.

Rethinking Roles and Functions

As the preceding discussion indicates, many influences are reshaping and will continue to alter the work of pupil personnel staff. Besides changes called for by the growing knowledge base in various disciplines and fields of practice, initiatives to restructure education and community health and human services are creating new roles and functions. Clearly, pupil service personnel will continue to be needed to provide targeted direct assistance and support. At the same time, their roles as advocates, catalysts, brokers, leaders, and facilitators of systemic reform will expand. As a result, they will engage in an increasingly wide array of activity to promote academic achievement and healthy development and address barriers to student learning. In doing so, they must be prepared to improve intervention outcomes by enhancing coordination and collaboration within a school and with community agencies in order to provide the type of cohesive approaches necessary to deal with the complex concerns confronting schools (Adelman, 1996a, 1996b; Center for Mental Health in Schools, 2001b, 2001c; Freeman & Pennekamp, 1988; Gysbers & Henderson, 2000, 2001; Lapan, 2001; Marx, Wooley, & Northrop, 1998; Reschly & Ysseldyke, 1995).

Consistent with current systemic changes is a trend toward less emphasis on intervention ownership and specialization and more attention to accomplishing desired outcomes through flexible and expanded roles and functions. This trend recognizes underlying commonalities among a variety of school concerns and intervention strategies and is fostering increased interest in cross-disciplinary training and interprofessional education (Carnegie Council on Adolescent Development, 1995; Lawson & Hooper-Briar, 1994).

Clearly, all this has major implications for changing pupil personnel professionals' roles, functions, preparation, and credentialing. Efforts to capture key implications are discussed in a recent report from the Center for Mental Health in Schools (2001d) entitled: Framing New Directions for School Counselors, Psychologists, & SocialWorkers.

New Mechanisms

With specific respect to improving how problems are prevented and ameliorated, all school personnel designated as student support staff need to lead the way in establishing well-redesigned organizational and operational mechanisms that can provide the means for schools to (a) arrive at wise decisions about resource allocation; (b) maximize systematic and integrated planning, implementation, maintenance, and evaluation of enabling activity; (c) outreach to create formal working relationships with community resources to bring some to a school and establish special linkages with others; and (d) upgrade and modernize interventions to reflect the best models and use of technology. As discussed above, implied in all this are new roles and functions. Also implied is redeployment of existing resources as well as finding new ones (Center for Mental Health in Schools, 2001b).

Concluding Comments

Over the next decade, initiatives to restructure education and community health and human services will reshape the work of school professionals who provide student support. Although some current roles and functions will continue, many will disappear, and others will emerge. Opportunities will arise not only to provide direct assistance but to play increasing roles as advocates, catalysts, brokers, and facilitators of reform and to provide various forms of consultation and inservice training. And, it should be emphasized that these additional duties include participation on school and district governance, planning, and evaluation bodies. All who work to address barriers to student learning must participate in capacity building activity that allows them to carry out new roles and functions effectively. This will require ending their marginalized status through full participation on school and district governance, planning, and evaluation bodies.

The next 20 years will mark a turning point for how schools and communities address the problems of children and youth. Currently being determined is: In what direction should schools go? And who should decide this? Where student support staff are not yet shaping the answers to these questions, they need to find a place at the relevant tables. Their expertise is needed in shaping policy, leadership, and mechanisms for developing school-wide and classroom programs to address barriers to learning and promote healthy development. There is much work to be done as the field redefines itself to play a key role in schools of the future.

References

Adelman, H.S. (1996a). Restructuring education support services and integrating community resources: Beyond the full service school model. School Psychology Review, 25, 431-445.

Adelman, H.S. (1996b). Restructuring support services: Toward a comprehensive approach. Kent, OH: American School Health Association.

Adelman, H.S., & Taylor, L. (1994). On understanding intervention in psychology and education. Westport, CT: Praeger.

Adelman, H.S., & Taylor, L. (1997). Addressing barriers to learning: Beyond school-linked services and full service schools. American Journal of Orthopsychiatry, 67, 408-421.

Adelman, H.S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. Educational Psychologist, 33, 135-152.

Adelman, H.S., & Taylor, L. (1999). Mental health in schools and system restructuring. Clinical Psychology Review, 19, 137-163.

Adelman, H.S., & Taylor, L. (2000a). Looking at school health and school reform policy through the lens of addressing barriers to learning. Children's Services: Social Policy, Research, and Practice, 3, 117-132.

Adler, L., & Gardner, S. (Eds.). (1994). The politics of linking schools and social services. Washington, DC: Falmer Press.

Carnegie Council on Adolescent Development. (1995). Great transitions: Preparing adolescents for a new century. New York: Carnegie Corporation.

Center for Mental Health in Schools. (1996). Policies and practices for addressing barriers to student learning: Current status and new directions. Los Angeles: Author At UCLA.

Center for Mental Health in Schools. (1997). Addressing barriers to learning: Closing gaps in school-community policy and practice. Los Angeles: Author at UCLA.

Center for Mental Health in Schools. (1998). Restructuring Boards of Education to enhance schools' effectiveness in addressing barriers to student learning. Los Angeles: Author at UCLA.

Center for Mental Health in Schools. (2000). Using technology to address barriers to learning. Los Angeles: Author at UCLA.

Center for Mental Health in Schools. (2001a). Violence prevention and safe schools. Los Angeles: Author at UCLA.

Center for Mental Health in Schools. (2001b). Resource?oriented teams: Key infrastructure mechanisms for enhancing education supports. Los Angeles: Author at UCLA.

Center for Mental Health in Schools. (2001c). Organization Facilitators: A Change Agent for Systemic School and Community Changes. Los Angeles: Author at UCLA.

Center for Mental Health in Schools. (2001d). Framing new directions for school counselors, psychologists, & social workers. Los Angeles: Author at UCLA.

Day, C., & Roberts, M.C. (1991). Activities of the Children and Adolescent Service System Program for improving mental health services for children and families. Journal of Clinical Child Psychology, 20, 340-350.

Dryfoos, J.G. (1994). Full-service schools: A revolution in health and social services for children, youth, and families. San Francisco: Jossey-Bass.

Dryfoos, J. (1998). Safe passage: Making it through adolescence in a risky society. New York: Oxford University Press.

Freeman, E.M., & Pennekamp, M. (1988). Social work practice: Toward a child, family, school, community perspective. Springfield, IL: Charles Thomas.

Gysbers, N.C., & Henderson, P. (2000). Developing and managing your school guidance program (3rd ed.). Alexandria, VA: American Counseling Association.

Gysbers, N.C., & Henderson, P. (2001). Comprehensive guidance and counseling programs: A rich history and a bright future. Professional School Counseling, 4, 246-256.

Knapp, M.S. (1995). How shall we study comprehensive collaborative services for children and families? Educational Researcher, 24, 5-16.

Kretzmann, J. & McKnight, J. (1993). Building communities from the inside out: A path toward finding and mobilizing a community's assets. Chicago: ACTA Publications.

Lapan, R.T. (2001). Comprehensive guidance and counseling programs: Theory, policy, practice, and research. Foreward to special issue. Professional School Counseling, 4, iv-v.

Lawson, H., & Briar-Lawson, K. (1997). Connecting the dots: Progress toward the integration of school reform, school-linked services, parent involvement and community schools. Oxford, OH: The Danforth Foundation and the Institute for Educational Renewal at Miami University.

Lawson, H., & Hooper-Briar, K. (1994). Expanding partnerships: Involving colleges and universities in interprofessional collaboration and service integration. Oxford, OH: The Danforth Foundation and the Institute for Educational Renewal at Miami University.

Lipsky, D.K., & Gartner, A. (1996). Inclusive education and school restructuring. In W. Stainback & S. Stainback (Eds.), Controversial issues confronting special education: Divergent perspectives (2nd ed., pp. 3-15). Boston: Allyn & Bacon.

Marx, E., Wooley, S., & Northrop, D. (1998). Health is academic. New York: Teachers College Press.

Melaville, A., & Blank, M.J. (1998). Learning together: The developing field of school-community initiatives. Flint, MI: Mott Foundation.

Merseth, K.K., Schorr, L.B., & Elmore, R.F. (2000). Schools, community-based interventions, and children's learning and development: What's the connect? In M.C. Wang & W.L. Boyd (Eds.), Improving results for children and families: Linking

collaborative services with school reform efforts. Greenwich, CT: Information Age Publishing.

Policy Leadership Cadre for Mental Health in Schools (2001). Mental Health in Schools: Guidelines, Models, Resources & Policy Considerations. Los Angeles: Center for Mental Health in Schools at UCLA.

Reschly, D.J., & Ysseldyke, J.E. (1995). School psychology paradigm shift. In A. Thomas & J. Grimes (Eds.), Best practices in school psychology (pp. 17-31). Washington, DC: National Association for School Psychologists.

Schorr, L.B. (1997). Common purpose. Strengthening families and neighborhoods to rebuild America. New York: Anchor Press.

SRI. (1996). California's Healthy Start school-linked services initiative: Summary of evaluation findings. Palo Alto, CA: SRI International.

Taylor, L., & Adelman, H.S. (2000). Connecting schools, families, and communities. Professional School Counseling, 3, 298-307.

U.S. Department of Education. (1995). School-linked comprehensive services for children and families: What we know and what we need to know. Washington, DC: Author.

U.S. General Accounting Office. (1993). School-linked services: A comprehensive strategy for aiding students at risk for school failure (GAO/HRD-94-21). Washington, DC: Author.

White, J.A., & Wehlage, G. (1995). Community collaboration: If it is such a good idea, why is it so hard to do? Educational Evaluation and Policy Analysis, 17, 23-38.

Mental Health in Schools
A Sampling of References
(from the Center's Quick Find Collection)

*1. On Mental Health in Schools**

Adelman, H.S. (1993). School-linked mental health interventions: Toward mechanisms for service coordination and integration. *Journal of Community Psychology, 21,* 309-319.

Adelman, H.S. (1994). On intervening to enhance home involvement in schooling. *Intervention in School and Clinic, 29,* 276-287.

Adelman, H.S. (1995). Clinical psychology: Beyond psychopathology and clinical interventions. *Clinical Psychology: Science and Practice, 2,* 28-44.

Adelman, H.S. (1996). Restructuring education support services and integrating community resources: Beyond the full service school model. *School Psychology Review, 25,* 431-445.

Adelman, H.S. (1998). School counseling, psychological, and social services. In E. Marx & S.F. Wooley, with D. Northrop (Eds.), *Health is academic: A Guide to coordinate school health programs.* Teachers College Press.

Adelman, H.S., Barker, L.A., & Nelson, P. (1993). A study of a school-based clinic: Who uses it and who doesn't? *Journal of Clinical Child Psychology, 22,* 52-59.

Adelman, H.S., Reyna, C., Collins, R., Onghai, J. & Taylor, L. (1999). Fundamental Concerns About Policy for Addressing Barriers to Student Learning. *Reading & Writing Quarterly, 15*(4), 327-350.

Adelman, H.S. & Taylor, L. (1993). School-based mental health: Toward a comprehensive approach. *Journal of Mental Health Administration, 20,* 32-45.

Adelman, H.S. & Taylor, L. (1997). Addressing barriers to learning: Beyond school- linked services and full service schools. *American Journal of Orthopsychiatry, 67,* 408-421.

Adelman, H.S. & Taylor, L. (1997). Toward a scale-up model for replicating new approaches to schooling. *Journal of Educational and Psychological Consultation, 8,* 197-230.

Adelman, H.S. & Taylor, L. (1998). Involving teachers in collaborative efforts to better address barriers to student learning. *Preventing School Failure, 42,* 55-60.

Adelman, H.S. & Taylor, L. (1998). Mental health in schools: Moving forward. *School Psychology Review, 27,* 175-190.

Adelman, H.S. & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. *Educational Psychologist, 33,* 135-152.

Adelman, H.S. & Taylor, L. (1999). Mental health in schools and system restructuring. *Clinical Psychology Review, 19,* 137-163.

Adelman, H.S. & Taylor, L. (2000). Moving Prevention From the Fringes Into the Fabric of School Improvement. *Journal of Educational and Psychological Consultation, 11*(1), 7-36.

Adelman, H.S. & Taylor, L. (2000). Promoting mental health in schools in the midst of school reform. *Journal of School Health, 70,* 171-178.

Adelman, H.S. & Taylor, L. (2000). Looking at School Health and School Reform Policy Through the Lens of Addressing Barriers to Learning. *Children's Services: Social Policy, Research, and Practice, 3,* 117-132.

Adelman, H.S. & Taylor, L. (2000). Shaping the Future of Mental Health in Schools. *Psychology in the Schools, 37,* 49-60.

Adelman, H.S. & Taylor, L. (2002). Impediments to enhancing availability of mental health services in schools: fragmentation, overspecialization, counterproductive competition, and marginalization. Paper comissioned by the National Association of School Psychologists and the ERIC Clearinghouse on Counseling and Student Services (ERIC/CASS). Published by the *ERIC/CASS Clearinghouse*. Accessible on internet from http://ericcass.uncg.edu/whatnew.html

Adelman, H.S., & Taylor, L. (in press). Creating school and community partnerships for substance abuse prevention programs. Commissioned by SAMHSA's Center for Substance Abuse Prevention. *Journal of Primary Prevention.*

Adelman, H.S., & Taylor, L. (in press). Toward a comprehensive policy vision for mental health in schools. In M. Weist, S. Evans, & N. Tashman (Eds.), *School mental health handbook.* Lawrence Erlbaum.

Adelman, H.S., & Taylor, L. (in press). School counselors and school reform: New directions. *Professional School Counseling*.
Adelman, H.S., & Taylor, L. (in press). Building comprehensive, multifaceted, and integrated approaches to address barriers to student learning. *Childhood Education*.
Adelman, H.S., Taylor, L., & Schneider, M. (1999). A school-wide component to address barriers to learning. *Reading and Writing Quarterly 15*, 277-302.
Adelman, H.S., Taylor, L., Weist, M.D., Adelsheim, S., Freeman, B., Kapp, L., Lahti, M., & Mawn, D. (1999). Mental health in schools: A federal initiative. *Children Services: Social Policy, Research, and Practice, 2*, 99-119.
Adler, L., & Gardner, S. (Eds.), (1994). *The politics of linking schools and social services*. Washington, DC: Falmer Press.
Albee, G.W., & Gullotta, T.P. (Eds.). (1997). *Primary prevention works*. Thousand Oaks, CA: Sage.
Anglin, T.M., Naylor, K.E., & Kaplan, D.W. (1996). Comprehensive, school-based health care: High school students' use of medical, mental health, and substance abuse services. *Pediatrics, 97*, 318-330.
Armbruster, P. Andrews, E., Couenhoven, J., Blau, G.(1999). Collision or collaboration? School-based health services meet managed care. *Clinical Psychology Review, 19*, 221-237.
Barker, L.A., & Adelman, H.S. (1994). Mental health status and help-seeking among ethnic minority adolescents. *Journal of Adolescence, 17*, 251-263.
Bickham, N.L., Pizarro, L.J., Warner, B.S., Rosenthal, B. & Weist, M.D. (1998). Family involvement in expanded school mental health. *Journal of School Health, 68*, 425-428.
Borders, L.D., & Drury, S.M. (1992). Comprehensive school counseling programs: A review for policymakers and practitioners. *Journal of Counseling & Development, 70*, 487-498.
Burchard, J.D. & Schaefer, M. (1992). Improving accountability in a service delivery system in children's mental health. *Clinical Psychology Review, 12*, 867-882.
Burns, B.J., Costello, E.J., Angold, A. Tweed, D., Strangl, D., Farmer, E., & Erkanli, A. (1995). Children's Mental Health Service Use Across Service Sectors. *Health Affairs, 14*, 147-159.
Bussing, R., Zima, B.T., Perwien, A.R., Belin, T.R., & Widawski, M. (1998). Children in special education programs: Attention deficit hyperactivity disorder, use of services, and unmet needs. *American Journal of Public Health, 88*, 880-886.
Cárdenas, J., Taylor, L., & Adelman, H.S. (1993). Transition support for immigrant students. *Journal of Multicultural Counseling and Development, 21*, 203-210.
Catalano, R. F., & Hawkins, J. D. (1995) *Risk-focused prevention: Using the social development strategy*. Seattle, WA.: Developmental Research and Programs, Inc.
Carlson, C., Paavola, J., & Talley, R. (1995). Historical, current, and future models of schools as health care delivery settings. *School Psychology Quarterly, 10*, 184-202.
Carnegie Council on Adolescent Development, (1988). *Review of school-based health services*. New York: Carnegie Foundation.
Center for Effective Collaboration and Practice, *Systems of Care: Promising Practices in Children's Mental Health*. Washington, DC: American Institutes for Research. http://www.air.org/cecp/promisingpractices/Default.htm
Center for Mental Health in Schools (2001). *Framing New Directions for School Counselors, Psychologists, & SocialWorkers*. Los Angeles: Author at UCLA.
Center for Mental Health in Schools. (1998). *Restructuring Boards of Education to enhance schools' effectiveness in addressing barriers to student learning*. Los Angeles: Author at UCLA
Costello, E.J. (1989). Developments in child psychiatric epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry, 28*, 836-841.
Cowen, E.L. (1997). On the semantics and operations of primary prevention and wellness enhancement (or will the real primary prevention please stand up?). *American Journal of Community Psychology, 25*, 245-257.
Cowen, E.L. Hightower, D.A., Pedro-Carroll, J.P., Work, W.C., Wyman, P.A., & Haffey, W.G. (1996). *School-based prevention of children at risk: The Primary Mental Health Project*. Washington, DC: American PsychologicalAssociation.

Cowen, E.L., Izzo, L.D., Miles, H., et al. (1963). A preventive mental health program in the school setting: Description and evaluation. *The Journal of School Psychology, 56*, 307-356.

Davis, N. J. (1999). *Resilience: Status of the Research and Research-Based Programs*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services: Washington, D.C.

Dryfoos, J.G. (1990). *Adolescents at risk: Prevalence and prevention*. London: Oxford University Press.

Dryfoos, J. G. (1998). *Safe passage: Making it through adolescence in a risky society*. New York: Oxford University Press.

Durlak, J.A. (1995). *School-based prevention programs for children and adolescents*. Thousand Oaks, CA: Sage.

Durlak, J.A., & Wells, A.M. (1997). Primary prevention programs for children and adolescents: A meta-analytic review. *American Journal of Community Psychology, 25*, 115-152.

Duttweiler, P.C. (1995). *Effective strategies for educating students in at risk situations*. Clemson, SC: National Dropout Prevention Center.

Elliott, D. S. (1998). *Blueprints for Violence Prevention*. Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado, Boulder. http://www.colorado.edu/cspv/blueprints/model/

Evans, S.W. (1999). Mental health services in schools: utilization, effectiveness, and consent *Clinical Psychology Review, 19*, 165-178.

Flaherty, L.T., Garrison, E.G., Waxman, R., Uris, P.F., Keys, S.G., Glass-Siegel, M. & Weist, M.D. (1998). Optimizing the roles of school mental health professionals. *Journal of School Health, 68*, 420-424.

Flaherty, L.T., Weist, M.D., & Warner, B.S. (1996). School-based mental health services in the United States: History, current models, and needs. *Community Mental Health Journal, 25*, 341-352.

Franklin, C. & Streeter, C.L. (1995). School reform: Linking public schools with human services. *Social Work, 40*, 773-782.

Friedman, R.M., Katz-Leavy, J., Manderscheid, R., & Sondheimer, D. (1996). Prevalence of serious emotional disturbance in children and adolescents. An update. In R.W. Manderscheid & M.A. Sonnenschein (Eds.), *Mental health, United States, 1998* (pp. 110-112

Garrison, E.G, Roy, I., Azar, V. (1999). Responding to the mental health needs of latino children and families through school-based services. *Clinical Psychology Review, 19*, 199-219.

Greenberg, M.T., Domitrovich, C., Bumbarger, B., (1999). *Preventing Mental Disorders in School-Aged Children: A Review of the Effectiveness of Prevention Programs*, Prevention Research Center for the Promotion of Human Development, College of Health and Human Development, Pennsylvania State University, February Draft.

Greene, R.W., & Ablon, J.S. (2001). What does the MTA study tell us about effective psychological treatment for ADHD? *Journal of Clinical Child Psychology, 30*, 114-121.

Hall, A. S., & Lin, M. (1995). Theory and practice of children's rights: Implications for mental health counselors. *Journal of Mental Health Counseling, 17*, 63-80.

Haynes, N.M., Comer, J.P., & Hamilton-Lee, M. (1988). The school development program: A model of school improvement. *Journal of Negro Education, 57*, 11-21.

Haynes, N.M., Comer, J.P., & Hamilton-Lee, M. (1988). The school development program: A model of school improvement. *Journal of Negro Education, 57*, 11-21.

Henggeler, S.W. (1995). A consensus: Conclusions of the APA Task Force report on innovative models or mental health services for children, adolescents, and their families. *Journal of Clinical Child Psychology, 23*, 3-6.

Hoagwood, K., & Erwin, H. (1997). Effectiveness of school-based mental health services for children: A 10-year research review. *Journal of Child and Family Studies, 6*, 435-451.

Hoagwood, K., Jensen, P. S.,Petti, T., &. Burns, B. J. (1996). Outcomes of Mental Health Care for Children and Adolescents: I. A Comprehensive Conceptual Model. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*.

Holtzman, W.H. (1992). (Ed.), Community renewal, family preservation, and child development through the School of the Future. In W.H. Holtzman, (Ed.), *School of the Future*. Austin, TX: American Psychological Association and Hogg Foundation for Mental Health.

Howard, K. A., Flora, J. & Griffen, M. (1999) Violence-prevention programs in schools: State of the science and implications for future research. *Applied & Preventive Psychology 8:* 197-215.
Institute of Medicine. (1994) *Reducing risks for mental disorders: Frontiers for preventive intervention research.* Washington, DC: National Academy Press.
Kazdin, A.E. (1993). Adolescent mental health: Prevention and treatment programs. *American Psychologist, 48,* 127-141.
Kazdin, A.E. (2000). *Psychotherapy for children and adolescents: Directions for research and practice.* New York: Oxford Univ. Press.
Kelleher, K.J., McInery, T.K., Gardner, W.P., Wasserman, R.C., & Stulp, C. (1997). Changing prevalence of clinician-identified psychosocial problems: 1979-1996. *Child Ambulatory Health, 3,* 156.
Kinney, J., Strand, K., Hagerup, M., & Bruner, C. (1994). *Beyond the buzzwords: Key principles in effective frontline practice.* Falls Church, VA: National Center for Service Integration and the National Resource Center for Family Support Programs.
Knitzer, J., Steinberg, Z., & Fleisch, B. (1990). *At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems.* NY: Bank Street College of Education.
Knoff, H., & Batsche, G. (1991). Integrating school and educational psychology to meet the educational and mental health needs of all children. *Educational Psychology, 26,* 167-183.
Kubiszyn, T. (1999). Integrating health and mental health services in schools: psychologists collaborating with primary care providers. *Clinical Psychology Review, 19,* 179-198.
Leaf, P.J., Alegria, M., Cohen, P., Goodman, S.H., Horwitz, S.M., Hoven, C.W., Narrow, W.E., Vadem-Kierman, M., & Reiger, D.A. (1996). *Mental health service use in the community and schools: Results from the four-community MECA Study.* (Methods for the Epidemiology of Child and Adolescent Mental Disorders Study.) Journal of the American Academy of Child and Adolescent Psychiatry, 35, 889-897.
Little Hoover Commission (2001). Executive Summary: *Young hearts & minds: Making a commitment to children's mental health.* CA.
Mazza, J.J. (1997). School-based suicide prevention programs: are they effective? *School Psychology Review 26,* 382-396.
Motes, P.S., Melton, G., Smith, L., & Freeman, B.V. (1996). *Developing comprehensive school-based mental health services.* Columbia, South Carolina: Institute for Families in Society.
Nabors, L.A., Weist, M.D., Holden, E.W., &Tashman, N.A. (1999).Quality Service Provision in Children's Mental Health Care. *Children's Services: Social Policy, Research, and Practice, 2,* 57-59.
NIMH (National Institute of Mental Health). (1998). *Priorities for prevention research.* NIH Publication No. 98-4321.
NIMH (National Institute of Mental Health). (1993). *The Prevention of Mental Disorders: A National Research Agenda.* Bethesda, MD: NMHA.
Nitz, K. (1999). Adolescent pregnancy prevention: a review of interventions and programs. *Clinical Psychology Review, 19,* 457-471.
Plante, T.G., Couchman, C.E., & Diaz, A.R. (1995). Measuring treatment outcome and client satisfaction among children and families. Special Section: Outcomes research. *Journal of Mental Health Administration, 22,* 261-269.
Policy Leadership Cadre for Mental Health in Schools (2001). Executive Summary: *Mental health in schools: guidelines, models, resources & policy considerations.* Los Angeles: Center for Mental Health in Schools at UCLA.
Quinn, M. M., Osher, D., Hoffman, C. (1999). *Safe, Drug-Free, and Effective Schools for ALL Students: What Works!* American Institutes for Research: Washington, D.C.
Rapport, M.D. (2001). Bridging theory and practice: Conceptual understanding of treatments for children with Attention Deficit Hyperactivity Disorder (ADHD), Obsessive-Compulsive Disorder (OCD), Autism, and Depression. *Journal of Clinical Child Psychology, 30,* 3-7.
Reppuci, N. D. (1999). Adolescent development and juvenile justice. *American Jounral of Community Psychology, 27,* 307-326.
Rones, M., & Hoagwood, K. (2000). School-Based Mental Health Services: A Research Review. *Clinical Child and Family Psychology Review, 3,* 223- 241.

Rosenblum, L., DiCecco, M.B., Taylor, L., & Adelman, H.S. (1995). Upgrading school support programs through collaboration: Resource Coordinating Teams. *Social Work in Education, 17,* 117- 124.

Schorr, L.B. (1997). *Common purpose: Strengthening families and neighborhoods to rebuild America.* New York: Anchor Books.

Sedlak, M.W. (1997). The uneasy alliance of mental health services and the schools: an historical perspective. *American Journal of Orthopsychiatry, 67*(3): 349-362.

Shields, J. M., & Johnson, A. (1992). Collision between law and ethics: Consent for treatment with adolescents. *Bulletin of the American Academy of Psychiatry and Law, 20,* 309-323.

Simoni, J., & Adelman, H.S. (1993). School-based mutual support groups for low-income parents. *The Urban Review, 25,* 335-350.

Steinberg, A.G., Gadomski, A., & Wilson, M.D. (1999). *Children's mental health: The changing interface between primary and specialty care.* Author at University of Pennsylvania.

Taylor, L. & Adelman, H.S. (1996). Mental health in the schools: Promising directions for practice. *Adolescent Medicine: State of the Art Reviews, 7,* 303-317.

Taylor, L. & Adelman, H.S. (2000). Connecting Schools, Families, and Communities. *Professional School Counseling, 3,* 298-307.

Taylor, L. & Adelman, H.S. (2000). Toward ending the marginalization of mental health in schools. *Journal of School Health, 70,* 210-215.Taylor, L., & Adelman, H.S. (2001). Enlisting appropriate parental cooperation and involvement in children's mental health treatment. In E.R. Welfel & R.E. Ingersoll (Eds.), *The mental health desk reference.* New York: John Wiley & Sons.

Taylor, L., & Adelman, H.S. (in press). Lessons learned from working with a district's mental health unit. *Childhood Education.*

Taylor, L., & Adelman, H.S.(in press). Advancing mental health in schools: Guiding frameworks and strategic approaches. In K. Robinson (Ed.), *Advances in school-based mental health.* Creative Research Institute.

Thomas, A., & Grimes, J. (Eds.). (1995). *Best practices in school psychology -- III.* Washington, DC: National Association for School Psychologists.

U.S. Dept. of Health and Human Services (2001). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Author. (www.surgeongeneral.gov/cmh/childreport.htm)

U.S. General Accounting Office (1993). *School-linked services: A comprehensive strategy for aiding students at risk for school failure.* (GAO/HRD-94-21). Washington, DC: Author.

Watkins, T. R., & Callicutt, J. W. (Eds.) (1997). *Mental health policy and practice today.* Thousand Oaks, CA: Sage.

Waxman, R.P., Weist M.D., Benson, D.M. (1999). Toward collaboration in the growing education-mental health interface. *Clinical Psychology Review, 19,* 239-253.

Weissberg, R.P., Gullotta, T.P., Hamptom, R.L., Ryan, B.A., & Adams, G.R. (Eds.). (1997). *Establishing preventive services,* pp. 253-289. Thousand Oaks, CA: Sage.

Weist, M.D. (1997). Expanded school mental health services: A national movement in progress. In T.H. Ollendick & R.J. Prinz (Eds.), *Advances in Clinical Child Psychology,* New York: Plenum.

Weist, M.D. (1997). Protective factors in childhood and adolescence. In J. Noshpitz (ed.), *Handbook of child and adolescent psychiatry,* V. 3., New York: Wiley.

Weist, M.D. (1999). Challenges and opportunities in expanded school mental health. Clinical Psychology Review, 19, 131-135.

Weist, M.D. (1999). Mental health services in schools: Expanding opportunities. In H. Ghuman & R. Sarles (Eds.), *Handbook of child and adolescent outpatient, day treatment, and community psychiatry.* New York: Brunner/Mazel.

Weist, M.D., Acosta, O.M., Tashman, N.A., Nabors, L.A., & Albus, K.A. (1999). Changing paradigms in child and adolescent psychiatry: Toward expanded school mental health. *Annals of Adolescent Psychiatry.*

Weist, M.D., Freedman, A.H., Paskewitz D.A., Proescher, E.J., & Flaherty L. T. (1995). Urban Youth Under Stress: Empirical Identification of Protective Factors. *Journal of Youth and Adolescence. 24,* 705-721.

Weist, M.D., Ginsberg, G.S., & Shafer, M.E. (1999). Progress in adolescent mental health. *Adolescent Medicine: State of the Art Reviews.*

Weist, M. D., Paskewitz, D. A., Warner, B. S., & Flaherty, L. T. (1996).Treatment outcome of school-based mental health services for urban teenagers. *Community Mental Health Journal. 32,* 149- 157.

Weist, M. D., Proescher, E. L., Freedman, A. H., Paskewitz, D. A., & Flaherty, L. T. (1995). School- based health services for urban adolescents: Psychosocial characteristics of clinic users vs. nonusers. *Journal of Youth and Adolescence, 24,* 251-259.

Weist, M.D. & Warner, B.S. (1999). School based violence interventions. *Annals of Adolescent Psychiatry.*

Weisz, J.R., Donenberg, G.R., Han, S.S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. .Journal of Consulting and Clinical Psychology, 63, 699-701.

2. A Few Compilations of Practices

Center for Mental Health in Schools. (1999). *Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning.* Los Angeles: Author.

Center for Mental Health Services (CMHS) *Knowledge Exchange Network* (KEN). This resource provides information about mental health, including reference to programs that are used by schools around the country. www.mentalhealth.org

Durlak, J.A. (1995). *School-based prevention programs for children and adolescents.* Thousand Oaks, CA: Sage.

Durlak, J.A. & Wells, A.M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. *American Journal of Community Psychology, 25,* 115-152.

Duttweiler, P.C. (1995). *Effective strategies for educating students in at risk situations.* Clemson, SC: National Dropout Prevention Center.

Elliott, D. S. (1998). *Blueprints for Violence Prevention. Center for the Study and Prevention of Violence.* Institute of Behavioral Science, University of Colorado, Boulder. http://www.colorado.edu/cspv/blueprints/model/

Goldman, R. (1997) (Ed.). Special section: Model mental health programs and educational reform.. *American Journal of Orthopsychiatry, 67.*

Greenberg, M.T., Domitrovich, C., & Bumbarger, B. (1999). *Preventing mental disorders in school-age children.* Prevention Research Center for the Promotion of Human Development, Pennsylvania State University.

Henggeler, S.W. (1995). A consensus: Conclusions of the APA Task Force report on innovative models of mental health services for children, adolescents, and their families. *Journal of Clinical Child Psychology, 23,* 3-6.

Han, Y.L., Waxman, R., & Warner, B.S. (1999). *Directory of expanded school-based mental health programs within the psychosocial section of NASBHC.* Center for School Mental Health Assistance, University of Maryland, Baltimore.

Hoagwood, K., & Erwin, H. (1997). Effectiveness of school-based mental health services for children: A 10-year research review. *Journal of Child and Family Studies, 6,* 435-451.

Melaville, A. & Blank, M.J. (1998). *Learning together: The developing field of school-communtiy initiatives.* Flint, MI: Mott Foundation.

Natasi, B., Varjas, K., & Bernstein, R. *Exemplary mental health programs: School psychologists as mental health providers.* Bethesda, MD: National Association of School Psychologists.

Scattergood, P, Dash, K., Epstein, J., & Adler, M. (1998). *Applying effective strategies to prevent or reduce substance abuse, violence, and disruptive behavior among youth.* Newton, MA: Educational Development Center, Inc.

Schorr, L.B. (1997). *Common purpose: Strengthening families and neighborhoods to rebuild America.* New York: Anchor Books.

Sedlak, M.W. (1997). The uneasy alliance of mental health services and the schools: A Historical perspective. *American Journal of Orthopsychiatry, 67,* 349-362.

Thomas, A., & Grimes, J. (Eds.). (1995). *Best practices in school psychology -- III.* Washington, DC: National Association for School Psychologists.

U.S. Department of Health and Human Services (1994). U.S. Department of Health and Human Services (1994). *School-based clinics that work.* U.S. Department of Health and Human Services, Public Health Service, Bureau of Primary Health Care, Rockville, MD.

W.T. Grant Consortium on the School-Based Promotion of Social Competence (1992). Drug and alcohol prevention curriculum. In J.D. Hawkins, et al. (Eds.), *Communities that care.* San Francisco: Jossey-Bass.

3. Some Documents on School Professional Standards and Guidelines

American Counseling Association's Council for Accreditation of Counseling and Related Educational Programs (CACREP) (1998 draft). The 2001 Standards. http://www.counseling.org/cacrep/2001standards700.htm

American School Health Association. *Guidelines for Comprehensive School Health Programs.* Kent, OH: Author.

California Commission on Teacher Credentialing (1998). *Recommended School Psychology Specialization Standards.* Sacramento, CA: Author.

California Commission on Teacher Credentialing (1998). *Preparing Educators for Partnerships with Families.* Sacramento, CA: Author.

National Association of School Psychologists (1994). *Standards for School Psychology: Training and Field Placement Programs; Standards for Credentialing.* Betheseda, MD: Author.

National Association of School Psychologists (1998). Standards for School Psychology: Future Directions in Training and Credentialing. Betheseda, MD: Author.

National Association of Social Workers (1992). *NASW Standards for School Social Work Services.* Betheseda, MD: Author.

National PTA (1998). *National Standards for Parent/Family Involvement Programs.* Author.

A Center Concept Paper . . .

Assuring No Child is Left Behind:

Strengthening the Approach of School and Community for Addressing Barriers to Student Learning

(From a center report entitled: *New Directions for School & Community Initiatives to Address Barriers to Learning: Two Examples of Concept Papers to Inform and Guide Policy Makers* February, 2002)

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA.

Write: Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095- 1563
Phone: (310) 825-3634 | Fax: (310) 206-8716 | E-mail: smhp@ucla.edu |
Website: http://smhp.psych.ucla.edu

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

Introduction: *Why a Concept Paper?*

School policy makers are beginning to understand that a considerable amount of resources are expended on student support services and various education support programs. These resources are allocated because of the widespread awareness that more is needed than the typical teacher can provide if some students are to succeed at school. At the same time, however, there is a growing concern that current efforts are not well-conceived and implemented. As a result, leaders for school improvement and those concerned with school-community collaboration are beginning to look for new directions.

The search for better ways to provide "learning supports" has led many school and community leaders to contact our Center. Over the past few years, we have provided them with information, frameworks, and guidelines outlining major new directions for systemic changes to better address barriers to learning and promote healthy development.

Recently, a new type of request emerged from several sources. The call was for an example of a brief, new directions "white paper" that could be given to school board members, district superintendents, and other policy shapers. Such a concise presentation was needed to highlight (a) the need and vision for developing a comprehensive, multifaceted, and integrated approach and (b) the type of major systemic changes that are involved.

This report contains two examples of such a concept paper. One was developed in working with an urban school district director of support services. It was composed as the basis for proposing a major restructuring initiative to the superintendent and the school board. The second example was prepared in work with a superintendent of a suburban school district who wanted a document to focus his initiative to restructure district efforts for addressing barriers to learning and enhance school-community collaboration.

Our experience in drafting these examples has convinced us of the value of a concept paper as a major tool in moving initiatives forward. We are recommending that leaders of any school and community efforts designed to enhance "learning supports" take time to prepare such a brief paper. In this respect, we hope these examples are of use. As with all the Center's work, everyone should feel free to use and/or adapt any aspect that will help efforts to strengthen young people, their families, schools, and neighborhoods.

Talking Points to Clarify the Rationale for Developing a Comprehensive, Multifaceted, and Integrated Approach

Why do we need to strengthen the school and community approach for ensuring that no child is left behind?

The School District and the community are determined to assure that no child is left behind. This means (1) enhancing what schools do to improve instruction ***and*** strengthening how they use the resources they deploy for providing student supports and (2) weaving in community resources to strengthen programs and fill gaps.

- To ensure that no child is left behind, every school and community need to work together to enhance efforts designed to increase the number of students who arrive each day ready and able to learn what the teacher has planned to teach.
- This involves helping significant numbers of students and their families overcome barriers to development and learning (including proactive steps to promote healthy development).
- Most barriers to learning arise from risk factors related to neighborhood, family, and peers. Many of these external barriers (along with those intrinsic to individual students) can and must be addressed by schools and communities so that youngsters have an equal opportunity to succeed at school.
- School districts usually have resources – people and programs – in place to help address barriers and enhance student readiness for learning each day. Communities also have relevant resources.
- At school sites, existing school-owned student support resources and community services that are linked to the school often are used in an ad hoc, fragmented, and marginalized way, and as a result, their impact is too limited and is not cost-effective.
- Reframing and restructuring the way in which these resources are used at a school site and then working with the school feeder patterns to create networks for effectively addressing barriers to learning is essential to enhancing impact and cost-effectiveness.
- A draft vision and outline or frameworks for pulling together these resources at schools (and for working with community resources) is outlined in the accompanying brief entitled: *Assuring No Child is Left Behind*, and in the Appendix: *Frameworks for a Component to Address Barriers to Student Learning*

Executive Summary

Assuring No Child is Left Behind:

Strengthening the Approach of School and Community for Addressing Barriers to Student Learning

School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.

Carnegie Council on Education Task Force

As schools pursue their mission to educate and as communities pursue the aim of improving the quality of life of their residents, major initiatives have been introduced and progress is being made. At the same time, it is evident that there remains considerable fragmentation and significant gaps in some of our efforts to assure no child is left behind. Fortunately, we have the opportunity and are at a place where we can take the next steps in strengthening our systems for addressing barriers to development and learning and promoting healthy development. Thus, this proposal highlights the type of comprehensive, multifaceted, and cohesive approach we need to develop and outlines how we can get there from here.

Note: This document incorporates research from the Center for Mental Health in Schools at UCLA. For more resources related to the frameworks outlined, contact Center co-directors Howard Adelman or Linda Taylor c/o Department of Psychology, UCLA, Box 951563, Los Angeles, CA 90095-1563 or call 310/825-3634 or use the internet to scan the website: http://smhp.psych.ucla.edu

Vision for Strengthening the District's Approach for Addressing Barriers to Student Learning*

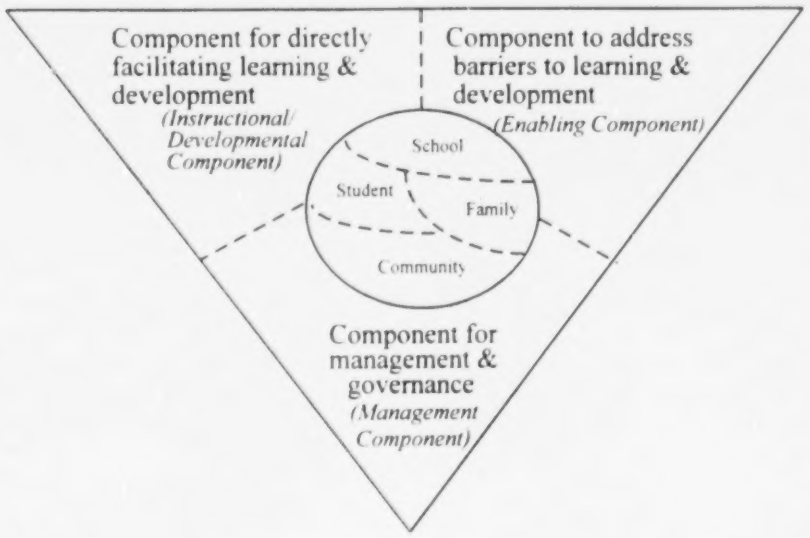
Our District has a long-history of assisting teachers in dealing with problems that interfere with school learning. Prominent examples are seen in the range of counseling, psychological, and social service programs we provide and in initiatives for enhancing students' assets and resiliency. We do a great deal, but the efforts are fragmented and often marginalized. As a result, our efforts are less effective than they can be. Therefore, after careful consideration, we are establishing as a priority the development of a comprehensive, multifaceted, and cohesive approach for addressing barriers to student learning and promoting healthy development.

In proceeding, we can draw upon and become part of pioneering initiatives emerging around the country that are rethinking how schools and communities meet the challenge of addressing persistent barriers to student learning and development. This initiative reflects a fundamental commitment to a three component framework for school improvement (see Figure 1).

* The notion of barriers to learning encompasses external and internal factors. Even the best schools find that *too many* youngsters are growing up in situations where significant external barriers regularly interfere with their reaching full potential. Some youngsters also bring with them intrinsic conditions that make learning and performing difficult. As a result, at every grade level there are students who come to school every day not quite ready to perform and learn in the most effective manner.

Addressing barriers is not at odds with the "paradigm shift" that emphasizes strengths, resilience, assets, and protective factors. Efforts to enhance positive development and improve instruction clearly can improve readiness to learn. However, it is frequently the case that preventing problems also requires direct action to remove or at least minimize the impact of barriers, such as hostile environments and intrinsic problems. Without effective direct intervention, such barriers can continue to get in the way of development and learning.

Figure 1. A three component framework for school improvement.



In developing a component to address barriers to learning and development, a major emphasis is on improving neighborhood, home, school and classroom environments to prevent problems and enhance youngsters' strengths. At the same time, essential supports and assistance are provided those who need something more to address barriers and engage or re-engage them in schooling and *enable* learning. This has led to calling this facet of school-community improvement an *Enabling Component.**

For individual youngsters, the intent of an Enabling Component is to prevent and minimize as many problems as feasible and to do so in ways that maximize engagement in productive learning. For the school and community as a whole, the intent is to produce a safe, healthy, nurturing environment/culture characterized by respect for differences, trust, caring, support, and high expectations. *(For more details, see appendix.)*

In accomplishing all this, the focus is on restructuring support programs and melding school, community, and home resources. The process is designed from the school outward. That is, the initial emphasis is on what the classroom and school must do to reach and teach all students effectively. Then, the focus moves to planning how the feeder pattern of schools and the surrounding community can complement each other's efforts and achieve economies of scale. Central district and community agency staff then restructure in ways that best support these efforts.

*Because the first initiatives have been undertaken by the education sector, some places use the term *Learning Support Component*; others use *Learner Support, Supportive Learning Environment*, or *Comprehensive Student Support System*. The usefulness of the concept of an Enabling Component as a broad unifying focal point for policy and practice is evidenced in its adoption by various states and localities around the country. These include the California Department of Education and the Los Angeles Unified School District, whose version is called a Learning Supports component, and the Hawai'i Department of Education, whose version is called a Comprehensive Student Support System. The concept of an Enabling Component also has been incorporated into the New American Schools' Urban Learning Center Model as a break-the-mold school reform initiative. The U. S. Department of Education recognized the Urban Learning Center Model as an important evolving demonstration of comprehensive school reform.

Getting From Here to There

See Exhibit on the following page for an outline of major tasks for moving forward. In brief, the proposed work involves broadening the vision and engagement of key stakeholders. This is followed by establishment of a steering committee to move the initiative forward. This encompasses establishing mechanisms to enhance the policy framework and develop the 5 year strategic plan. Once the plan is appropriately revised based on stakeholder feedback, the steering committee pursues approval and ensures implementation.

The emphasis in planning is first and foremost on working with the school district to clarify how each school can restructure and improve use of existing resources. It should detail the programmatic focus and necessary infrastructure changes at schools, for the feeder pattern, and district- and community wide. It should delineate the processes related to establishing desired systemic-changes and define the role and functions of change agents in implementing these processes. Throughout, the emphasis will be on redeploying existing resources, enhancing connections beyween school and community resources, and capitalizing on the expertise and resources of those who are facilitating similar initiatives around the country (e.g., the Center for Mental Health at UCLA.)

One of the first implementation steps should be the use of a cadre of specially trained change agents working with an administrative leader at each school to establish a resource-oriented team. The team can then map existing school and community programs and services that support students, families, and staff. This will generate a comprehensive form of needs assessment as the resource mapping is paired with surveys of the unmet needs of youngsters, their families, and school and community staff. The task then will be to analyze what is available, effective, and needed as a basis for formulating strategies to use existing resources more effectively.

In a similar fashion, a resource-oriented team for the feeder pattern should be established to analyze the situation with a view to cross-school and community-wide cooperation and integration in order to enhance intervention effectiveness and garner school district- and community-wide economies of scale.

To ensure that the whole process is data-driven, the community should ensure that it has an effective system for generating a yearly community report card. And, the school district should expand its framework for school accountability. That is, in addition to the continued focus on high standards for academic performance, accountability must encompass all facets of a comprehensive, multifaceted approach to addressing barriers to learning and promoting healthy development. Thus, over time, the district's data gathering increasingly should reflect quality indicators of our high standards for learning related to social and personal functioning and for activity directly designed to address barriers to student learning. The former will emphasize measures of social learning and behavior, character/values, civility, healthy and safe behavior, and other facets of youth development. The latter will include benchmark indicators such as increased attendance, reduced tardies, reduced misbehavior, less bullying and sexual harassment, increased family involvement with child and schooling, fewer referrals for specialized assistance, fewer referrals for special education, and fewer pregnancies, suspension, and dropouts.

Concluding Comments

For some youngsters, regular development and improvement in school performance and academic achievement are hampered because of the absence of comprehensive, multifaceted, and cohesive approaches for addressing barriers to development and learning. At this stage in the ongoing development of our schools and community, it is essential to take the next steps toward ensuring such approaches are in place. By doing so, we move closer to fulfilling the intent of assuring every child reaches full potential and no child is left behind.

Exhibit: What are some of the first steps in getting from here to there?

(1) Broadening the Collaborative's Vision

- Collaborative leadership builds consensus that the aim of those involved is to help weave together community and school resources to develop a comprehensive, multifaceted, and integrated continuum of interventions so that no child is left behind.

(2) Writing a "Brief" to Clarify the Vision

- Collaborative establishes a writing team to prepare a "white paper," Executive Summary and set of "talking points" clarifying the vision by delineating the rationale and frameworks that will guide development of a comprehensive, multifaceted, and integrated approach (see appended example)

(3) Establishing a Steering Committee to Move the Initiative Forward and Monitor Process

- Collaborative identifies and empowers a representative subgroup who will be responsible and accountable for ensuring that the vision ("big picture") is not lost and the momentum of the initiative is maintained through establishing and monitoring ad hoc work groups that are asked to pursue specific tasks

(4) Starting a Process for Translating the Vision into Policy

- Steering Committee establishes a work group to prepare a campaign geared to key local and state school and agency policy makers that focuses on (a) establishing a policy framework for the development of a comprehensive, multifaceted, and integrated approach and (b) ensuring that such policy has a high enough level of priority to end the current marginalized status such efforts have at schools and in communities

(5) Developing a 5 year Strategic Plan

- Steering Committee establishes a work group to draft a 5 year strategic plan that delineates (a) the development of a comprehensive, multifaceted, and integrated approach and (b) the steps to be taken to accomplish the required systemic changes (The strategic plan will cover such matters as use of formulation of essential agreements about policy, resources, and practices; assignment of committed leadership; change agents to facilitate systemic changes; infrastructure redesign; enhancement of infrastructure mechanisms; resource mapping, analysis, and redeployment; capacity building; standards, evaluation, quality improvement, and accountability; "social marketing.")

- Steering Committee circulates draft of plan (a) to elicit suggested revisions from key stakeholders and (b) as part of a process for building consensus and developing readiness for proceeding with its implementation

- Work group makes relevant revisions based on suggestions

(6) Moving the Strategic Plan to Implementation

- Steering Committee ensures that key stakeholders finalize and approve strategic plan

- Steering Committee submits plan on behalf of key stakeholders to school and agency decision makers to formulate formal agreements (e.g., MOUs, contracts) for start-up, initial implementation, and on-going revisions that can ensure institutionalization and periodic renewal of a comprehensive, multifaceted, and integrated approach

- Steering Committee establishes work group to develop action plan for start-up and initial implementation (The action plan will identify general functions and key tasks to be accomplished, necessary systemic changes, and how to get from here to there in terms of who carries out specific tasks, how, by when, who monitors, etc.)

APPENDIX

Frameworks for a Component to Address Barriers to Development & Learning

Because of the many factors that can cause problems, schools and communities must be prepared to use a wide range of responses. Moreover, attention should be given not only to responding to problems, but to preventing them. This means that a component to address barriers to development and learning must be comprehensive and multifaceted. To be effective, it must be implemented in an integrated and systematic manner.

A widely advocated framework for understanding the range of interventions needed outlines a continuum consisting of

- systems for promoting healthy development and preventing problems
- systems for intervening early to address problems as soon after onset as is feasible
- systems for assisting those with chronic and severe problems (see Figure 3).

This continuum encompasses approaches for enabling academic, social, emotional, and physical development and addressing learning, behavior, and emotional problems. Most schools and communities have some programs and services that fit along the entire continuum.

A second framework helps to further organize thinking about these programs and services. The framework uses six arenas of activity to categorize and capture the essence of the multifaceted ways schools working with communities need to address barriers to development and learning (see Figure 3).* The six categories encompass efforts to effectively

- enhance regular classroom strategies to improve instruction for students with mild-moderate behavior and learning problems
- assist students and families as they negotiate the many school-related transitions
- increase home involvement with schools
- respond to and where feasible prevent crises
- increase community involvement and support (including enhanced use of volunteers)
- facilitate student and family access to specialized services when necessary.

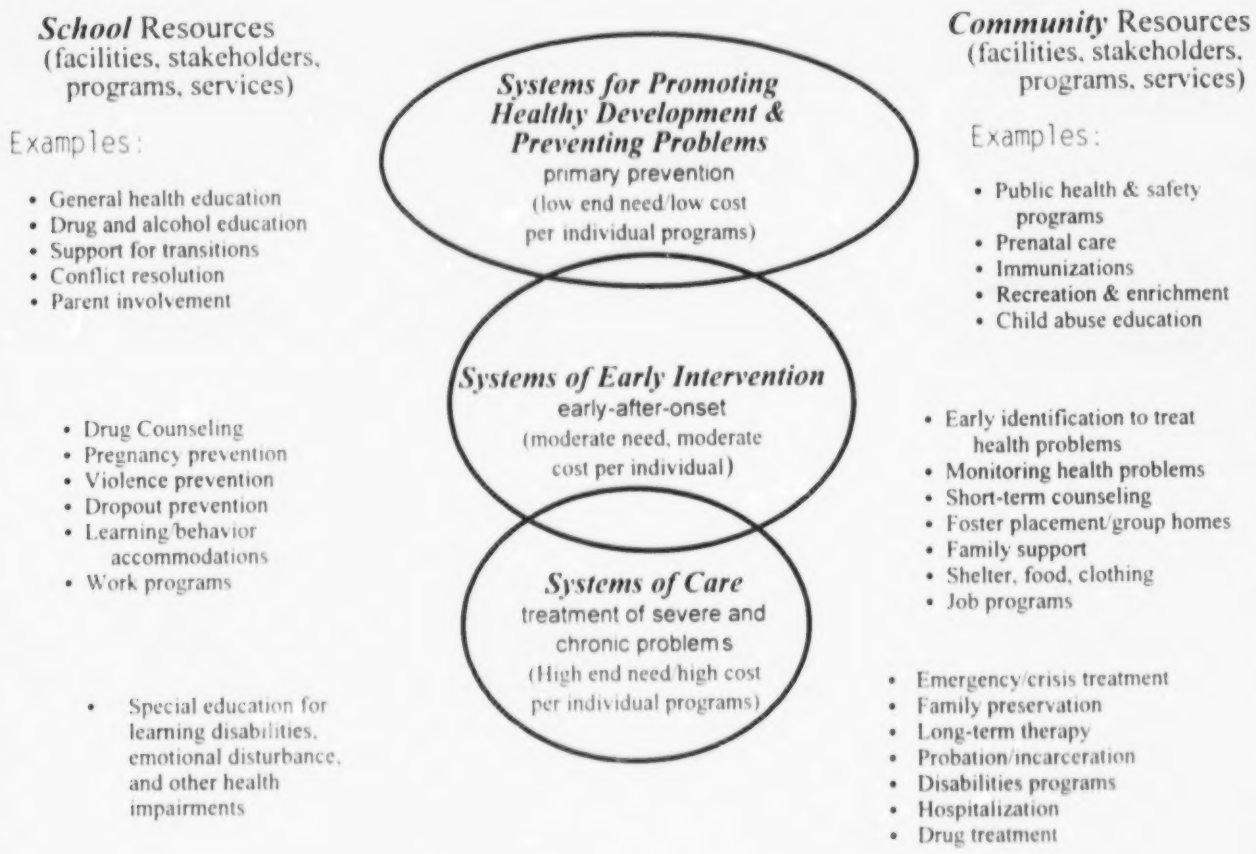
Each of these is described briefly in the Exhibit following Figure 3.

---

*This framework was developed as part of research on education support programs. The six programmatic arenas are conceived as the curriculum of a component to address barriers to learning.

It also should be noted that there is a growing research base that supports an array of activities for addressing behavior, learning, and emotional problems. This research base is reviewed in several documents prepared by the Center for Mental Health in Schools at UCLA. These include: *A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning* and *Addressing Barriers to Student Learning & Promoting Healthy Development: A Usable Research-Base.* These documents can be downloaded from the Center's website – http://smhp.psych.ucla.edu

Figure 2. Interconnected systems for meeting the needs of all students.

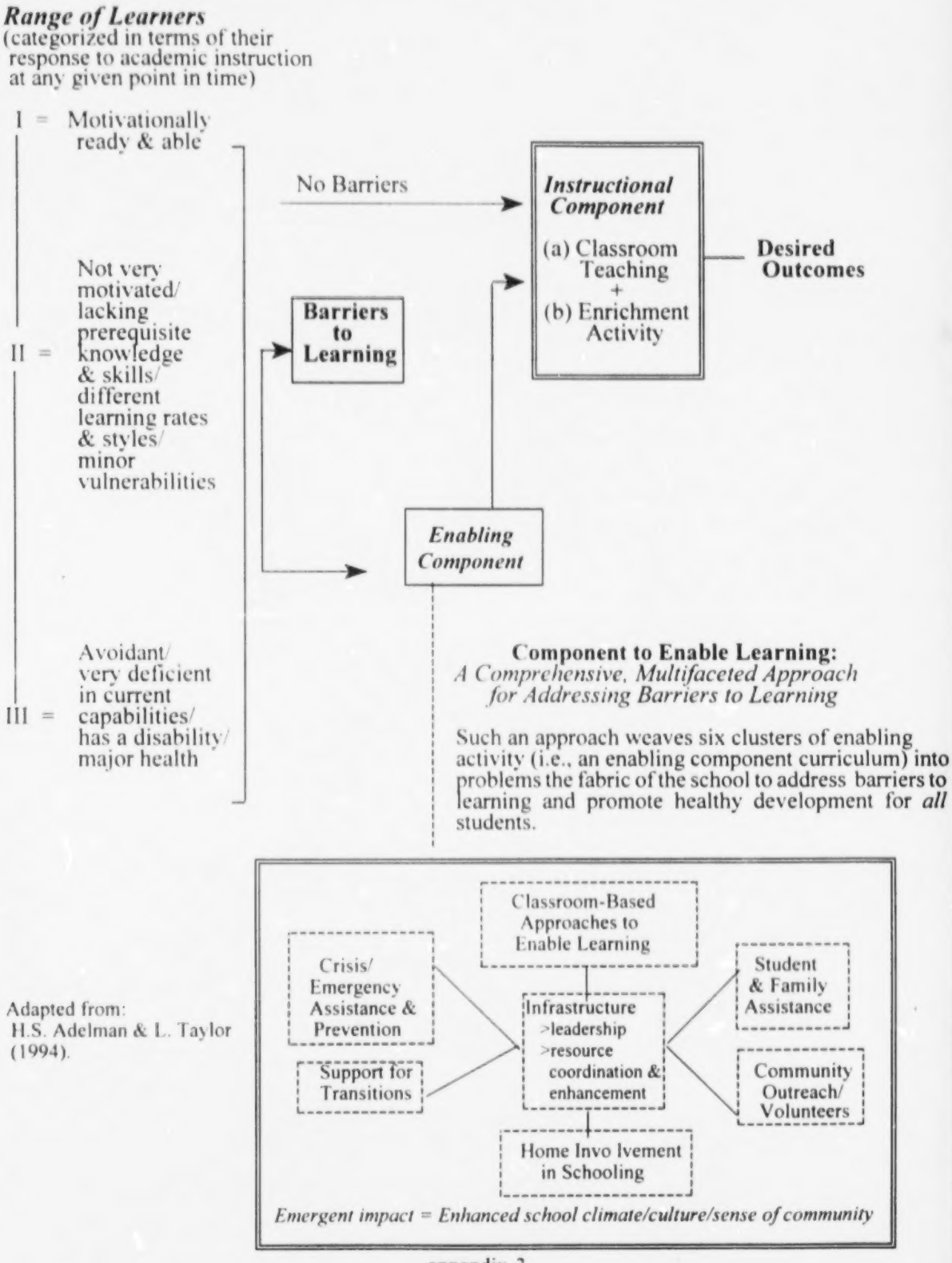


Systemic collaboration* is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among *systems* of *prevention, systems* of *early intervention*, and *systems of care*.

*Such collaboration involves horizontal and vertical restructuring of programs and services
(a) within jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools)
(b) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies

Adapted from various public domain documents authored by H. S. Adelman & L. Taylor and circulated through the Center for Mental Health in Schools at UCLA.

Figure 3. An enabling component to address barriers to learning and enhance healthy development at a school site.


Range of Learners
(categorized in terms of their response to academic instruction at any given point in time)
I = Motivationally ready & able
II = Not very motivated/ lacking prerequisite knowledge & skills/ different learning rates & styles/ minor vulnerabilities
III = Avoidant/ very deficient in current capabilities/ has a disability/ major health
No Barriers
Barriers to Learning
Instructional Component
(a) Classroom Teaching
+
(b) Enrichment Activity
Desired Outcomes
Enabling Component
Component to Enable Learning:
A Comprehensive, Multifaceted Approach for Addressing Barriers to Learning
Such an approach weaves six clusters of enabling activity (i.e., an enabling component curriculum) into problems the fabric of the school to address barriers to learning and promote healthy development for all students.
Classroom-Based Approaches to Enable Learning
Crisis/ Emergency Assistance & Prevention
Support for Transitions
Infrastructure
>leadership
>resource coordination & enhancement
Student & Family Assistance
Community Outreach/ Volunteers
Home Involvement in Schooling
Emergent impact = Enhanced school climate/culture/sense of community

Adapted from:
H.S. Adelman & L. Taylor (1994).

Exhibit

Six Arenas of Programmatic Activity to Address Barriers to Student Learning

1. Classroom focused enabling. Programmatic activity to enhance classroom-based efforts to enable learning is accomplished by increasing teachers' effectiveness in accommodating a wider range of individual differences, fostering a caring context for learning, and preventing and handling a wider range of problems. Such efforts are essential to increasing the effectiveness of classroom instruction, supporting inclusionary policies, and reducing the need for specialized services. Work in this area requires systematic programs to (a) personalize professional development of staff, (b) develop the capabilities of paraeducators, assistants, and volunteers, (c) provide temporary out of class assistance for students, and (d) enhance resources in the classroom.

2. Support for transitions. Students and their families are regularly confronted with a variety of transitions (e.g., changing schools, changing grades, inclusion from special education, before and after school transitions, school-to-work, or postsecondary education). Examples of transition programs include (a) school-wide activities for welcoming new arrivals and ensuring on-going social supports, (b) articulation strategies to support grade transitions and special education transitions, and (c) before and after school and vacation activities to enrich learning and provide recreation in a safe environment.

3. Home involvement in schooling. A range of programs are included here. They include activities to (a) address the learning and support needs of adults in the home, (b) help families learn how to support students with schoolwork, (c) improve communication and connections between home and school, and (d) elicit collaborations and partnerships from those at home to meet school and community needs.

4. Crisis assistance and prevention. Schools must respond to, minimize the impact of, and prevent crises. This requires systematic programs for (a) emergency response at a school and community wide and (b) minimizing risk factors to prevent crises related to violence, suicide, and child abuse. A key mechanism in this area is development of a crisis team educated in emergency response procedures. The team can take the lead in planning ways to prevent crisis by developing programs for conflict mediation and enhancing a caring school culture.

5. Student and family assistance. This one area encompasses most of the services that are the focus of integrated service models. Social, physical, and mental health assistance available in the school and community are integrated to provide personalized services. Systems for triage, case, and resource management increase consistency and effectiveness.

6. Community outreach for involvement and support. Most schools do their job better when they are an integral and positive part of the community. For schools to be integral, steps must be taken to create and maintain collaborative connections. Outreach can be made to (a) public and private agencies, (b) higher education, (c) businesses and professionals, (d) churches, and (e) volunteer service organizations. One facet of all this outreach is establishment of programs designed to recruit, train, and maintain volunteers to assist students in school programs.

Infrastructure for the Component

Addressing barriers to development and learning calls for some changes in *infrastructure* at schools and district- and community-wide. In building the infrastructure, the focus begins with school level mechanisms. Once these are established, mechanisms can be developed that enable the feeder pattern to work together to increase efficiency and effectiveness and achieve economies of scale. System-wide mechanisms are then redesigned based on what must be done at the district and community level to support the work at each school and family of schools.

An effective component to address barriers to development and learning requires mechanisms that provide the means for schools and communtiies to (a) arrive at wise decisions about allocating resources for enabling activity; (b) maximize integrated planning, implementation, maintenance, and evaluation of systematic activity; © outreach to create formal working relationships with each other's resources to bring some to a school and establish special linkages with others; and (d) upgrade and modernize interventions to reflect the best models and use of technology. As the following examples illustrate, implied in all this are new roles and functions for administrators and staff.

Resource-oriented teams. Creation of resource-oriented teams provides essential mechanisms for enhancing attention to developing a comprehensive, multifaceted, and cohesive approach. Resource-oriented teams encourage programs to function in an increasingly cohesive way. They are vehicles for building working relationships and can play a role in solving turf and operational problems. They encourage weaving together existing school and community resources.

A resource-oriented team both manages and enhances *systems* for coordination, integration, and strengthening of interventions. Such a team must be part of the structure of every school. Then, a representative must be designated to connect with the feeder pattern and with district-wide and community steering groups.

A resource-oriented team differs from a case-oriented team. That is, its focus is not on reviewing specific individuals, but on clarifying resources and their best use. This is a role that existing case-oriented teams can play if they are asked to broaden their scope.

At a school-site, a "Resource Coordinating Team" can be responsible for (a) identifying and analyzing activity and resources with a view to improving efforts to prevent and ameliorate problems; (b) ensuring there are effective systems for prereferral intervention, referral, monitoring of care, and quality improvement; (c) guaranteeing effective procedures for program management and communication among school staff and with the home; and (d) exploring ways to redeploy and enhance resources. This last function includes clarifying which activities are nonproductive and suggesting better uses for the resources, as well as reaching out to connect with additional resources in the school district and community.

Administrative leadership. Administrative leads for an Enabling Component provide essential site and system-wide guidance and assistance at each school and district- and community-wide. Such leadership ensures daily implementation, monitoring, and problem solving. At school sites and at central offices, specific leadership functions include (a) evolving the vision and strategic plans for preventing and ameliorating problems; (b) ensuring coordination and integration of enabling activity; and (c) ensuring integration with the developmental/instructional and management components.

District- and community- wide functions also include enhancing linkages and integrated collaboration among school programs and with those operated by community, city, and county agencies. And, of course, central offices ensure equity, conduct quality improvement reviews, and ascertain how well outcomes are achieved.

Some Characteristics of a Comprehensive, Multifaceted Approach to Addressing Barriers to Development and Learning

As described in the research literature, the concept of an Enabling Component embraces a focus on healthy development, prevention, and addressing barriers. Thus, it is not a case of a negative vs. a positive emphasis (or excusing or blaming anyone). It's not about what's wrong vs. what's right with kids. It is about continuing to face up to the reality of major extrinsic barriers, as well as personal vulnerabilities and real disorders and disabilities – all factors that can interfere with a youngster reaching full potential.

The focus begins in the classroom, with differentiated classroom practices as the base of support for each youngster. This includes:

- Addressing barriers through a broader view of "basics" and through effective accommodation of learner differences

- Enhancing the focus on motivational considerations with a special emphasis on intrinsic motivation as it relates to learner readiness and ongoing involvement and with the intent of fostering intrinsic motivation as a basic outcome

- Adding remediation as necessary, but only as necessary.
  (Remedial procedures are added to instructional programs for certain individuals, but only after appropriate nonremedial procedures for facilitating learning have been tried. Moreover, such procedures are designed to build on strengths and are not allowed to supplant a continuing emphasis on promoting healthy development.)

Beyond the classroom, policy, leadership, and mechanisms ensure school- and community-wide programs address barriers to development, learning, parenting, and teaching. Youngsters and families feel they are truly welcome at school and throughout the community and experience a range of social supports. Some of this activity requires partnering among schools, some requires weaving school and community resources and programs together. An array of programs focuses on prevention and early intervention to ensure that the supports provided and the delivery process correspond to the severity, complexity, and frequency of each youngster's needs. School and community programs enhance a caring atmosphere by promoting cooperative learning, peer tutoring, mentoring, human relations, and conflict resolution. Emerging from all this is an overall school and neighborhood climate that encourages mutual support and caring and creates a sense of community. Such an atmosphere plays a key role in preventing learning, behavior, emotional, and health problems.

School Mental Health Project/Center for Mental Health in Schools at UCLA

In an effort to advance the field, the School Mental Health Project was established in 1986 in the Department of Psychology at UCLA to pursue theory, research, practice, and training related to addressing mental health and psychosocial concerns through school-based interventions. Under the auspices of the Project, the national Center for Mental Health in Schools was funded in 1995 and, in October, 2000, began a second five year cycle of operation. The Center is one of two national centers focusing directly on mental health in schools.[1] Its goals are to enhance *in strategic ways* (1) availability of and access to resources to improve and advance MH in schools, (2) the capacity of systems/personnel, and (3) the role of schools in addressing MH, psychosocial, and related health concerns.

From the perspective of the guiding frameworks described in various works generated by the project/center staff, addressing MH of youngsters involves ensuring

- mental *illness* is understood within the broader perspective of psychosocial and related health problems and in terms of strengths as well as deficits
- the roles of schools/communities/homes are enhanced and pursued jointly
- equity considerations are confronted
- the marginalization and fragmentation of policy, organizations, and daily practice are countered
- the challenges of evidence-based strategies and achieving results are addressed.

Thus, the Center's work aims not only at improving practitioners' competence, but at fostering changes in the systems with which they work. Such activity also addresses the varying needs of locales and the problems of accommodating diversity among those trained and among populations served.

Given the number of schools across the country, resource centers such as ours must work in well-conceived strategic ways. Thus, our emphasis is on expanding programmatic efforts that enable all student to have an equal opportunity to succeed at school and on accomplishing essential systemic changes for sustainability and scale-up through (a) enhancing resource availability and the systems for delivering resources, (b) building state and local capacity, (c) improving policy, and (d) developing leadership.

The strategies for accomplishing all this include

- connecting with major initiatives of foundations, federal government & policy bodies, and national associations;
- connecting with major initiatives of state departments and policy bodies, counties, and school districts;
- collaborating and network building for program expansion and systemic change;
- providing catalytic training to stimulate interest in program expansion and systemic change;
- catalytic use of technical assistance, internet, publications, resource materials, and regional meetings to stimulate interest in program expansion and systemic change.

Because we know that schools are not in the mental health business, all our work strives to approach mental health and psychosocial concerns in ways that integrally connect with school reform. We do this by integrating health and related concerns into the broad perspective of addressing barriers to learning and promoting healthy development. We stress the need to restructure current policy and practice to enable development of a comprehensive and cohesive approach that is an essential and primary component of school reform, without which many students cannot benefit from instructional reforms and thus achievement scores will not rise in the way current accountability pressures demand.

---

1. The other national center, called the Center for School Mental Health Assistance, is located at the University of Maryland at Baltimore and is directed by Mark Weist. Both Centers are partially supported by the U.S. Dept. of Health and Human Services through the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.